System Automation

MyLicense Transaction Reports

Reports Home Page

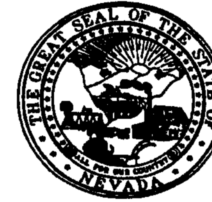
Renewal Questions for License Number 6314

Licensee	Question	Answer	Date
ROTHMAN, Stephen L Gabriel	Do you have a medical condition which in any way impairs or limits your ability to practice medicine with reasonable skill and safety? **If you do not have a medical condition, select No.**	N	6/29/2015
ROTHMAN, Stephen L Gabriel	If you have a medical condition which in any way impairs or limits your ability to practice medicine, is that impairment or limitation reduced or ameliorated because of the field of practice, the setting, the manner in which you have chosen to practice, or by any other reasonable accommodation? **If you do not have a medical condition, select No.**	N	6/29/2015
ROTHMAN, Stephen L Gabriel	If you use chemical substances, does your use in any way impair or limit your ability to practice medicine with reasonable skill and safety? **If you do not use chemical substances, select No.**	N	6/29/2015
ROTHMAN, Stephen L Gabriel	Have you been named as a defendant, or been requested to respond as a defendant, to a legal action involving professional liability, malpractice, including any military tort claims if applicable? Please include: who, what, where (provide state), and when in the textbox directly below this question.	N	6/29/2015
ROTHMAN, Stephen L Gabriel	Have you had a professional liability, malpractice, claim paid on your behalf or paid such a claim yourself including any military tort claims if applicable? If "Yes" during the time period July 1, 2013 - June 30, 2015 type an explanation in the textbox directly below this question.	N	6/29/2015
ROTHMAN, Stephen L Gabriel	Have you been arrested, investigated for, charged with, convicted of, or pled guilty or nolo contendere to any offense or violation of any federal (including the Uniform Code of Military Justice), state or local law, or the laws of any foreign country, which is a misdemeanor, gross misdemeanor, felony, violation of the Uniform Code of Military Justice, or synonymous thereto in a foreign jurisdiction, excluding any minor traffic offense (driving or being in control of a motor vehicle while under the influence of a chemical substance, including alcohol, is not considered a minor traffic offense), or for any offense which is related to the manufacture, distribution, prescribing, or dispensing of controlled substances? **Please note that you MUST disclose ANY investigation or arrest, including those where the final disposition was dismissal, or expungement.**	N	6/29/2015
ROTHMAN, Stephen L Gabriel	Have you been denied a license, permission to practice medicine or any other healing art, or permission to take an examination to practice medicine or any other healing art in any state, country or U.S. territory?	N	6/29/2015
ROTHMAN, Stephen L Gabriel	Have you had a medical license or license to practice any other healing art revoked, suspended, limited, or restricted in any state, country or U.S. territory?	N	6/29/2015
ROTHMAN, Stephen L Gabriel	Have you voluntarily surrendered a license to practice medicine or any other healing art in any state, country or U.S. territory in lieu of any disciplinary action?	N	6/29/2015

ROTHMAN, Stephen L Gabriel	Have you failed to initiate the performance of public service within one year after the date the public service is required to begin to satisfy a requirement of your receiving a loan or scholarship from the federal government or a state or local government for your medical education?	N	6/29/2015
ROTHMAN, Stephen L Gabriel	Have you been: a) asked to respond to an investigation; b) notified that you were under investigation for; c) investigated for; d) charged with; or e) convicted of any violation of a statute, rule or regulation governing your practice as a physician by any medical licensing board, hospital, medical society, governmental entity or agency other than the Nevada State Board of Medical Examiners?	N	6/29/2015
ROTHMAN, Stephen L Gabriel	Have you surrendered your state or federal controlled substance registration or had it revoked or restricted in any way?	N	6/29/2015
ROTHMAN, Stephen L Gabriel	Have you had hospital staff privileges denied, suspended, limited, revoked or not renewed by the hospital, including any and all resignations from any medical staff in lieu of disciplinary or administrative action? If the answer is "Yes," type the name of the hospital, the hospital's mailing address, the type of action taken, and the date or dates of the actions taken in the textbox directly below this question. **(Please Note: Do not include suspensions or restrictions for failure to complete hospital medical records, attend hospital department or staff meetings, or maintain required malpractice insurance.)**	N	6/29/2015
ROTHMAN, Stephen L Gabriel	Have you actively practiced medicine in Nevada within the past 12 months?	N	6/29/2015
ROTHMAN, Stephen L Gabriel	**Explanation 14: For the above question if your answer is "No" for the time period July 1, 2013 – June 30, 2015, or since your last renewal, please type your brief explanation in this text box (Fields are space limited to 256 characters).Lengthy explanations or additional information may be faxed to 775-688-2551 or scanned and Email to elicensensbme@medboard.nv.gov!.**		6/29/2015
ROTHMAN, Stephen L Gabriel	OPTION TO CHANGE LICENSE STATUS FROM ACTIVE TO INACTIVE: NOTE: If you choose to drop to Inactive status during this renewal, your status will be changed to "Inactive" **as of the date of your renewal**. If you do NOT wish to change your status to "Inactive" as of today, DO NOT COMPLETE YOUR RENEWAL UNTIL SUCH TIME AS YOU ARE PREPARED TO HAVE YOUR STATUS CHANGED (prior to JULY 1ST). For your information, your answers to the questions that you've already completed will remain, but you should not complete the renewal and pay until such time as you are prepared to change your status to "Inactive." I hereby request my license to be placed on Inactive status, which means I will not physically practice in the state of Nevada. If you choose to place your license on Inactive status, make certain to select "Yes" to this question **AND** choose the Inactive status in the dropdown box located at the end of the questions.	N	6/29/2015
ROTHMAN, Stephen L Gabriel	**If you believe that you are in compliance with the Centers for Disease Control safe injection practices, your answer should be "YES".** I hereby attest to knowledge of and compliance with the guidelines of the Centers for Disease Control and Prevention concerning the prevention of transmission of infectious agents through safe and appropriate injection practices. I also attest that any person who is currently, or will be under my control as their supervising physician in the future, and who is not licensed pursuant to chapter 630 of the Nevada Revised Statutes and whose duties involve injection practices, has knowledge of and is in compliance with the	Y	6/29/2015

	guidelines of the Centers for Disease Control and Prevention concerning the prevention of transmission of infectious agents through safe and appropriate injection practices. **http://www.cdc.gov/injectionsafety/IP07_standardPrecaution.html**		
ROTHMAN, Stephen L Gabriel	I hereby attest that I am in compliance with the reporting requirements of NRS 630.30665, and am aware that failure to submit a report or filing false information in a report is grounds for disciplinary action under Nevada's Medical Practice Act. I HAVE SUBMITTED A "FORM A" OR "FORM B" REPORT TO THE BOARD. Instructions and Forms A and B for in-office surgery/procedure reporting can be located on the Board's website by clicking the red "In-Office Surgery Reporting" link on the home page of the Board's website: www.medboard.nv.gov. **If you have submitted your in-office surgery/procedure reporting forms (A/B Forms) to the Board and are in compliance with NRS 630.30665, your answer should be "YES."**	Y	6/29/2015
ROTHMAN, Stephen L Gabriel	Are you out of compliance with court ordered child support? **If this does not apply to you, please answer "no".** If "Yes" during the time period July 1, 2013 - June 30, 2015 type an explanation in the textbox directly below this question.	N	6/29/2015
ROTHMAN, Stephen L Gabriel	Once you have read the statute regarding the reporting of the abuse or neglect of a child, your answer to this question will be "YES". **I attest and affirm that I am aware of and understand the reporting requirements found in Nevada Revised Statute 432B.220 regarding the abuse or neglect of a child.** **www.leg.state.nv.us/NRS/NRS-432B.html#NRS432BSec220**	Y	6/29/2015
ROTHMAN, Stephen L Gabriel	Have you ever served in the United States Military (to include National Guard or Reserves)?	Y	6/29/2015
ROTHMAN, Stephen L Gabriel	**Explanation 17: If your answer is "No", you do not have to provide information in the text box for the remaining questions regarding the Military Service Attestation.** 1. If yes, in which branch of service did you serve? 2. What was your Military occupation specialty or specialties? 3. Provide your dates of service in the Military.	-	6/29/2015
ROTHMAN, Stephen L Gabriel	Do you hold a Nevada state business license issued in your individual name?	N	6/29/2015
ROTHMAN, Stephen L Gabriel	I have completed the required amount of AMA Category 1 CME within the current biennial. I understand that I may be included in a random audit. I agree to retain CME's taken between July 1, 2013 and June 30, 2015. (Review CME information online at www.medboard.nv.gov) If renewing to an Inactive status, CME is not required and "No" can be selected.	Y	6/29/2015
ROTHMAN, Stephen L Gabriel	I SWEAR OR AFFIRM UNDER THE PENALTY OF PERJURY THAT I PERSONALLY ANSWERED ALL OF THE QUESTIONS IN THIS APPLICATION AND THAT THE ANSWERS I HAVE PROVIDED ARE TRUE AND CORRECT.	Y	6/29/2015

Nevada State Board of Medical Examiners



Renewal Responses Report

Wednesday, January 27, 2016

License Number	Licensee	License Type
6314	Stephen L Gabriel ROTHMAN	Medical Doctor

Question	Answer	Date
Do you have a medical condition which in any way impairs or limits your ability to practice medicine with reasonable skill and safety? If you answer "Yes" during the time period July 1, 2005 - June 30, 2007 email to elicensensbme@medboard.nv.gov	N	06/21/2007

Question	Response	Date
If you have a medical condition which in any way impairs or limits your ability to practice medicine, is that impairment or limitation reduced or ameliorated because of the field of practice, the setting, or the manner in which you have chosen to practice? If you answer "Yes" during the time period July 1, 2005 - June 30, 2007 email to elicensensbme@medboard.nv.gov	N	06/21/2007
If you use chemical substances, does your use in any way impair or limit your ability to practice medicine with reasonable skill and safety? If you answer "Yes" during the time period July 1, 2005 - June 30, 2007 email to elicensensbme@medboard.nv.gov	N	06/21/2007

Question	Response	Date
Have you failed to initiate the performance of public service within one year after the date the public service is required to begin to satisfy a requirement of your receiving a loan or scholarship from the federal government or a state or local government for your medical education?	N	06/21/2007
Have you been named as a defendant, or been requested to respond as a defendant, to a legal action involving professional liability (malpractice), or had a professional liability claim paid on your behalf, or paid such a claim yourself?	N	06/21/2007

Question	Response	Date
Have you been investigated for, arrested for, charged with, convicted of, or plead guilty or nolo contendere to any offense or violation of any federal (including the U.S. Military), state or local law, including any foreign country, which is in a foreign jurisdiction equivalent to, a misdemeanor, gross misdemeanor, court martial, or felony, excluding any minor traffic offense (driving or being in control of a motor vehicle while under the influence of any chemical substance and/or including alcohol, is not considered a minor traffic offense), or for any offense which is related to the manufacture, distribution, prescribing, or dispensing of controlled substances? Please note that you MUST disclose ANY investigation or arrest, even if the ultimate disposition was dismissal or expungement. If you answer "Yes" during the time period July 1, 2005 - June 30, 2007 email to elicensensbme@medboard.nv.gov	N	06/21/2007
Have you been denied a license, permission to practice medicine or any other healing art, or permission to take an examination to practice medicine or any other healing art in any state, country or U.S. territory? If "Yes" during the time period July 1, 2005-June 30-2007 e-mail explanation to email to elicensensbme@medboard.nv.gov.	N	06/21/2007

Question	Response	Date
Have you had a medical license or license to practice any other healing art revoked, suspended, limited, or restricted in any state, country or U.S. territory? If "Yes" during the time period July 1, 2005-June 30-2007 e-mail explanation to email to elicensensbme@medboard.nv.gov.	N	06/21/2007
Have you voluntarily surrendered a license to practice medicine or any other healing art in any state, country or U.S. territory by the direct request of a medical board? If "Yes" during the time period July 1, 2005-June 30-2007 e-mail explanation to email to elicensensbme@medboard.nv.gov.	N	06/21/2007

Question	Response	Date
Have you been denied membership or expelled from a medical society or other professional medical organization? If "Yes" during the time period July 1, 2005-June 30-2007 e-mail explanation to email to elicensensbme@medboard.nv.gov.	N	06/21/2007
Have you been: a) notified that you were under investigation for; b) investigated for; c) charged with; or d) convicted of any violation of a statute, rule or regulation governing your practice as a physician by any medical licensing board, hospital, medical society, governmental entity or agency other than the Nevada State Board of Medical Examiners? If "Yes" during the time period July 1, 2005-June 30-2007 e-mail explanation to email to elicensensbme@medboard.nv.gov.	N	06/21/2007

Question	Response	Date
Have you surrendered your state or federal controlled substance registration or had it revoked or restricted in any way? If "Yes" during the time period July 1, 2005-June 30-2007 e-mail explanation to email to elicensensbme@medboard.nv.gov.	N	06/21/2007
Have you had hospital staff privileges denied, suspended, limited, revoked or not renewed by the hospital? *If you have answered "Yes" you will be required to submit a list of any and all resignations from any medical staff in lieu of disciplinary or administrative action via email to elicensensbme@medboard.nv.gov (Please Note: Do not include suspensions or restrictions for failure to complete hospital medical records, attend hospital department or staff meetings, or maintain required malpractice insurance.)* If "Yes" during the time period July 1, 2005-June 30-2007 e-mail explanation to email to elicensensbme@medboard.nv.gov.	N	06/21/2007

Question	Response	Date
Is your license currently contingent upon compliance with the Diversion program also known as the Nevada Health Professionals Assistance Foundation? If "Yes" during the time period July 1, 2005-June 30-2007 e-mail explanation to email to elicensensbme@medboard.nv.gov.	N	06/21/2007
Are you a foreign medical doctor, who holds a Conditional Resident Alien Card, Employment Authorization Card, or Visa with the Department of Homeland Security, Immigration and Naturalization Services? If "yes" please fax a copy of proof to (775) 688-2551 ATTN:Online License Renewal.	N	06/21/2007

Question	Response	Date
Are you out of compliance with court ordered child support? **If this does not apply to you please answer "no".** If "Yes" during the time period July 1, 2005-June 30-2007 e-mail explanation to email to elicensensbme@medboard.nv.gov.	N	06/21/2007
I HEREBY SWEAR OR AFFIRM UNDER THE PENALTIES OF PERJURY THAT I AM IN FULL COMPLIANCE WITH ANY AND ALL OBLIGATIONS, TERMS OR CONDITIONS OF MY NEVADA MEDICAL LICENSE SPECIFIED BY THE BOARD.	Y	06/21/2007

Question	Answer	Date
Do you have a medical condition which in any way impairs or limits your ability to practice medicine with reasonable skill and safety? **If you do not have a medical condition, select No.**	N	05/19/2009

Explanation 1: For the above question if your answer is "Yes" for the time period July 1, 2007 - June 30, 2009, or since your last renewal, please type your explanation in this text box.

If you have a medical condition which in any way impairs or limits your ability to practice medicine, is that impairment or limitation reduced or ameliorated because of the field of practice, the setting, or the manner in which you have chosen to practice?
If you do not have a medical condition, select No.

N

05/19/2009

Explanation 2: For the above question if your answer is "Yes" for the time period July 1, 2007 - June 30, 2009, or since your last renewal, please type your explanation in this text box.

Question	Answer	Date
If you use chemical substances, does your use in any way impair or limit your ability to practice medicine with reasonable skill and safety? **If you do not use chemical substances, select No.**	N	05/19/2009

Explanation 3: For the above question if your answer is "Yes" for the time period July 1, 2007 - June 30, 2009, or since your last renewal, please type your explanation in this text box.

Question	Answer	Date
Have you been named as a defendant, or been requested to respond as a defendant or potential defendant, to a legal action involving professional liability (malpractice)? Please include: who, what, where (provide state), and when in the textbox directly below this question.	N	05/19/2009

Explanation 4: For the above question if your answer is "Yes" for the time period July 1, 2007 - June 30, 2009, or since your last renewal, please type your explanation in this text box.

Have you had a professional liability (malpractice) claim paid on your behalf or paid such a claim yourself (including any military tort claims if applicable)? N 05/19/2009
Please include: who, what, where (provide state), when and case number in the textbox directly below this question.
Please fax a copy of the complaint, civil or otherwise to 775-688-2551.

Explanation 5: For the above question if your answer is "Yes" for the time period July 1, 2007 - June 30, 2009, or since your last renewal, please type your explanation in this text box.
Please fax a copy of the complaint, civil or otherwise to 775-688-2551.

Question	Response	Date
Have you been arrested, investigated for, charged with, convicted of, or pled guilty or nolo contendere to any criminal offense related to the manufacture, distribution, prescribing, or dispensing of controlled substances?**Please note that you MUST disclose ANY investigation or arrest, including those where the final disposition was dismissal, sealing of a record, or expungement.**	N	05/19/2009

Explanation 6: For the above question if your answer is "Yes" for the time period July 1, 2007 - June 30, 2009, or since your last renewal, please type your explanation in this text box.

Have you been arrested, investigated for, charged with, convicted of, or pled guilty or nolo contendere to any criminal offense other than a criminal offense listed in Question #6? **Please note that you MUST disclose ANY investigation or arrest, including those where the final disposition was dismissal, sealing of a record, or expungement.** N 05/19/2009

Explanation 7: For the above question if your answer is "Yes" for the time period July 1, 2007 - June 30, 2009, or since your last renewal, please type your explanation in this text box.

Question	Answer	Date
Have you been denied a license, permission to practice medicine or any other healing art, or permission to take an examination to practice medicine or any other healing art in any state, country or U.S. territory?	N	05/19/2009

Explanation 8: For the above question if your answer is "Yes" for the time period July 1, 2007 - June 30, 2009, or since your last renewal, please type your explanation in this text box.

Question	Answer	Date
Have you had a medical license or license to practice any other healing art revoked, suspended, limited, or restricted in any state, country or U.S. territory?	N	05/19/2009

Explanation 9: For the above question if your answer is "Yes" for the time period July 1, 2007 - June 30, 2009, or since your last renewal, please type your explanation in this text box.

Question	Answer	Date
Have you voluntarily surrendered a license to practice medicine or any other healing art in any state, country or U.S. territory in lieu of any disciplinary action?	N	05/19/2009

Explanation 10: For the above question if your answer is "Yes" for the time period July 1, 2007 - June 30, 2009, or since your last renewal, please type your explanation in this text box.

Question	Answer	Date
Have you been denied membership, been asked to resign or expelled from a medical society or other professional medical organization (including the ABMS)?	N	05/19/2009

Explanation 11: For the above question if your answer is "Yes" for the time period July 1, 2007 - June 30, 2009, or since your last renewal, please type your explanation in this text box.

Question	Response	Date
Regarding any medical licensing board, hospital medical society, or other governmental entity or agency (other than the Nevada State Board of Medical Examiners), have you been: (a) Asked to respond to an investigation; (b) Notified that you were under investigation for; (c) Investigated for; (d) Charged with; or (e) Convicted of any violation of a statute, rule or regulation governing your practice as a physician?	N	05/19/2009

Explanation 12: For the above question if your answer is "Yes" for the time period July 1, 2007 - June 30, 2009, or since your last renewal, please type your explanation in this text box.

Question	Answer	Date
Have you surrendered your state or federal controlled substance registration or had it revoked or restricted in any way?	N	05/19/2009

Explanation 13: For the above question if your answer is "Yes" for the time period July 1, 2007 - June 30, 2009, or since your last renewal, please type your explanation in this text box.

Have you had hospital staff privileges denied, suspended, limited, revoked or not renewed by the hospital, including any and all resignations from any medical staff in lieu of disciplinary or administrative action? If the answer is " Yes," type the name of the hospital, the hospital's mailing address, the type of action taken, and the date or dates of the actions taken in the textbox directly below this question.
(Please Note:) Do not include suspensions or restrictions for failure to complete hospital medical records, attend hospital department or staff meetings, or maintain required malpractice insurance.) N 05/19/2009

Explanation 14: For the above question if your answer is "Yes" for the time period July 1, 2007 - June 30, 2009, or since your last renewal, please type your explanation in this text box.

Are you out of compliance with court ordered child support? **If this does not apply to you, please answer "no".** If "Yes" during the time period July 1, 2007- June 30, 2009 type an explanation in the textbox directly below this question.	N	05/19/2009

Explanation 15: For the above question if your answer is "YES" for the time period July 1, 2007 - June 30, 2009, or since your last renewal, please type your explanation in this text box.

I hereby request my license to be placed on Inactive status, which means I will not physically practice in the state of Nevada. If you choose to place your license on Inactive status, make certain to select "Yes" to this question **AND** choose the Inactive status in the dropdown box located at the end of the questions.	N	05/19/2009

Explanation 16: For the above question, if your answer is "Yes" and you want to change to Inactive status for the next biennial July 1, 2009 – June 30, 2011, please provide a brief explanation in this text box.

Do you want to change your scope of practice or specialty?
If you answer "Yes" type your current scope of practice or specialty in the textbox directly below this question.

N

05/19/2009

Explanation 17: For the above question if your answer is "YES" , please type your new scope of practice or specialty in this text box.

Question	Response	Date
I have completed the required amount of AMA Category 1 CME within the current biennial. (Review CME information online at www.medboard.nv.gov) I understand that I may be included in a random audit following the July 1st, 2009 renewal. I agree to retain CME's taken between July 1, 2007 and June 30, 2009. If renewing to an Inactive status, CME is not required and "No" can be selected.	Y	05/19/2009
I SWEAR OR AFFIRM UNDER THE PENALTY OF PERJURY THAT I PERSONALLY ANSWERED ALL OF THE QUESTIONS IN THIS APPLICATION AND THAT THE ANSWERS I HAVE PROVIDED ARE TRUE AND CORRECT.	Y	05/19/2009

Question	Answer	Date
Do you have a medical condition which in any way impairs or limits your ability to practice medicine with reasonable skill and safety? **If you do not have a medical condition, select No.**	N	06/12/2011

Explanation 1: For the above question if your answer is "Yes" for the time period July 1, 2009 - June 30, 2011, or since your last renewal, please type your explanation in this text box.

If you have a medical condition which in any way impairs or limits your ability to practice medicine, is that impairment or limitation reduced or ameliorated because of the field of practice, the setting, or the manner in which you have chosen to practice? **If you do not have a medical condition, select No.**	N	06/12/2011

Explanation 2: For the above question if your answer is "Yes" for the time period July 1, 2009 - June 30, 2011, or since your last renewal, please type your explanation in this text box.

If you use chemical substances, does your use in any way impair or limit your ability to practice medicine with reasonable skill and safety?
If you do not use chemical substances, select No.

N

06/12/2011

Explanation 3: For the above question if your answer is "Yes" for the time period July 1, 2009 - June 30, 2011, or since your last renewal, please type your explanation in this text box.

Have you been named as a defendant, or been requested to respond as a defendant, to a legal action involving professional liability, malpractice, including any military tort claims if applicable?
Please include: who, what, where (provide state), and when in the textbox directly below this question. Y 06/12/2011

Explanation 4: For the above question if your answer is "Yes" for the time period July 1, 2009 - June 30, 2011, or since your last renewal, please type your explanation in this text box. 06/12/2011

Question	Answer	Date
Have you had a professional liability, malpractice, claim paid on your behalf or paid such a claim yourself including any military tort claims if applicable? If "Yes" during the time period July 1, 2009 - June 30, 2011 type an explanation in the textbox directly below this question.	N	06/12/2011

Explanation 5: For the above question if your answer is "Yes" for the time period July 1, 2009 - June 30, 2011, or since your last renewal, please type your explanation in this text box.
Please fax a copy of the complaint, civil or otherwise to 775-688-2551.

Have you been arrested, investigated for, charged with, convicted of, or pled guilty or nolo contendere to any offense or violation of any federal (including the Uniform Code of Military Justice), state or local law, or the laws of any foreign country, which is a misdemeanor, gross misdemeanor, felony, violation of the Uniform Code of Military Justice, or synonymous thereto in a foreign jurisdiction, excluding any minor traffic offense (driving or being in control of a motor vehicle while under the influence of a chemical substance, including alcohol, is not considered a minor traffic offense), or for any offense which is related to the manufacture, distribution, prescribing, or dispensing of controlled substances? **Please note that you MUST disclose ANY investigation or arrest, including those where the final disposition was dismissal, or expungement.** N 06/12/2011

Explanation 6: For the above question if your answer is "Yes" for the time period July 1, 2009 - June 30, 2011, or since your last renewal, please type your explanation in this text box.

Have you been denied a license, permission to practice medicine or any other healing art, or permission to take an examination to practice medicine or any other healing art in any state, country or U.S. territory?	N	06/12/2011

Explanation 7: For the above question if your answer is "Yes" for the time period July 1, 2009 - June 30, 2011, or since your last renewal, please type your explanation in this text box.

Have you had a medical license or license to practice any other healing art revoked, suspended, limited, or restricted in any state, country or U.S. territory?	N	06/12/2011

Explanation 8: For the above question if your answer is "Yes" for the time period July 1, 2009 - June 30, 2011, or since your last renewal, please type your explanation in this text box.

Have you voluntarily surrendered a license to practice medicine or any other healing art in any state, country or U.S. territory in lieu of any disciplinary action? N 06/12/2011

Explanation 9: For the above question if your answer is "Yes" for the time period July 1, 2009 - June 30, 2011, or since your last renewal, please type your explanation in this text box.

Question	Answer	Date
Have you been denied membership, been asked to resign or expelled from a medical society or other professional medical organization (including the ABMS)?	N	06/12/2011

Explanation 10: For the above question if your answer is "Yes" for the time period July 1, 2009 - June 30, 2011, or since your last renewal, please type your explanation in this text box.

Have you been: a) asked to respond to an investigation; b) notified that you were under investigation for; c) investigated for; d) charged with; or e) convicted of any violation of a statute, rule or regulation governing your practice as a physician by any medical licensing board, hospital, medical society, governmental entity or agency other than the Nevada State Board of Medical Examiners? N 06/12/2011

Explanation 11: For the above question if your answer is "Yes" for the time period July 1, 2009 - June 30, 2011, or since your last renewal, please type your explanation in this text box.

Question	Answer	Date
Have you surrendered your state or federal controlled substance registration or had it revoked or restricted in any way?	N	06/12/2011

Explanation 12: For the above question if your answer is "Yes" for the time period July 1, 2009 - June 30, 2011, or since your last renewal, please type your explanation in this text box.

Have you had hospital staff privileges denied, suspended, limited, revoked or not renewed by the hospital, including any and all resignations from any medical staff in lieu of disciplinary or administrative action? If the answer is " Yes," type the name of the hospital, the hospital's mailing address, the type of action taken, and the date or dates of the actions taken in the textbox directly below this question. **(<u>Please Note</u>:) Do not include suspensions or restrictions for failure to complete hospital medical records, attend hospital department or staff meetings, or maintain required malpractice insurance.)**	N	06/12/2011

Explanation 13: For the above question if your answer is "Yes" for the time period July 1, 2009 - June 30, 2011, or since your last renewal, please type your explanation in this text box.

Are you out of compliance with court ordered child support? **If this does not apply to you, please answer "no".** N 06/12/2011

If "Yes" during the time period July 1, 2009 - June 30, 2011 type an explanation in the textbox directly below this question.

Explanation 14: For the above question if your answer is "YES" for the time period July 1, 2009 - June 30, 2011, or since your last renewal, please type your explanation in this text box.

Question	Response	Date
I hereby request my license to be placed on Inactive status, which means I will not physically practice in the state of Nevada. If you choose to place your license on Inactive status, make certain to select "Yes" to this question **AND** choose the Inactive status in the dropdown box located at the end of the questions.	N	06/12/2011

Explanation 15: For the above question, if your answer is "Yes" and you want to change to Inactive status for the next biennial July 1, 2011 – June 30, 2013, please provide a brief explanation in this text box.

Question	Answer	Date
Is your license contingent upon maintaining certification with the American Board of Medical Specialties (ABMS) in the specialty of Family Practice, Emergency Medicine, or Preventative Medicine?	N	06/12/2011

Explanation 16: For the above question if your answer is "YES" , please type your new scope of practice or specialty in this text box.

Question	Answer	Date
Do you want to change your scope of practice or specialty? If you answer "Yes" type your current scope of practice or specialty in the textbox directly below this question.	N	06/12/2011

Explanation 17: For the above question if your answer is "Yes" for the time period July 1, 2009 - June 30, 2011, or since your last renewal, please type your explanation in this text box.

Question	Response	Date
I have completed the required amount of AMA Category 1 CME within the current biennial. (Review CME information online at www.medboard.nv.gov) I understand that I may be included in a random audit following the July 1st, 2011 renewal. I agree to retain CME's taken between July 1, 2009 and June 30, 2011. If renewing to an Inactive status, CME is not required and "No" can be selected.	Y	06/12/2011
I SWEAR OR AFFIRM UNDER THE PENALTY OF PERJURY THAT I PERSONALLY ANSWERED ALL OF THE QUESTIONS IN THIS APPLICATION AND THAT THE ANSWERS I HAVE PROVIDED ARE TRUE AND CORRECT.	Y	06/12/2011

Question	Response	Date
Do you have a medical condition which in any way impairs or limits your ability to practice medicine with reasonable skill and safety? **If you do not have a medical condition, select No.**	N	05/05/2013
If you have a medical condition which in any way impairs or limits your ability to practice medicine, is that impairment or limitation reduced or ameliorated because of the field of practice, the setting, or the manner in which you have chosen to practice? **If you do not have a medical condition, select No.**	N	05/05/2013

Question	Response	Date
If you use chemical substances, does your use in any way impair or limit your ability to practice medicine with reasonable skill and safety? **If you do not use chemical substances, select No.**	N	05/05/2013
Have you been named as a defendant, or been requested to respond as a defendant, to a legal action involving professional liability, malpractice, including any military tort claims if applicable? Please include: who, what, where (provide state), and when in the textbox directly below this question.	N	05/05/2013

Question	Response	Date
Have you had a professional liability, malpractice, claim paid on your behalf or paid such a claim yourself including any military tort claims if applicable? If "Yes" during the time period July 1, 2011 - June 30, 2013 type an explanation in the textbox directly below this question.	N	05/05/2013
Have you been arrested, investigated for, charged with, convicted of, or pled guilty or nolo contendere to any offense or violation of any federal (including the Uniform Code of Military Justice), state or local law, or the laws of any foreign country, which is a misdemeanor, gross misdemeanor, felony, violation of the Uniform Code of Military Justice, or synonymous thereto in a foreign jurisdiction, excluding any minor traffic offense (driving or being in control of a motor vehicle while under the influence of a chemical substance, including alcohol, is not considered a minor traffic offense), or for any offense which is related to the manufacture, distribution, prescribing, or dispensing of controlled substances? **Please note that you MUST disclose ANY investigation or arrest, including those where the final disposition was dismissal, or expungement.**	N	05/05/2013

Question	Response	Date
Have you been denied a license, permission to practice medicine or any other healing art, or permission to take an examination to practice medicine or any other healing art in any state, country or U.S. territory?	N	05/05/2013
Have you had a medical license or license to practice any other healing art revoked, suspended, limited, or restricted in any state, country or U.S. territory?	N	05/05/2013

Question	Response	Date
Have you voluntarily surrendered a license to practice medicine or any other healing art in any state, country or U.S. territory in lieu of any disciplinary action?	N	05/05/2013
Have you failed to initiate the performance of public service within one year after the date the public service is required to begin to satisfy a requirement of your receiving a loan or scholarship from the federal government or a state or local government for your medical education?	N	05/05/2013

Question	Response	Date
If you believe that you are in compliance with the Centers for Disease Control safe injection practices, your answer should be "YES". I hereby attest to knowledge of and compliance with the guidelines of the Centers for Disease Control and Prevention concerning the prevention of transmission of infectious agents through safe and appropriate injection practices. I also attest that any person who is currently, or will be under my control as their supervising physician in the future, and who is not licensed pursuant to chapter 630 of the Nevada Revised Statutes and whose duties involve injection practices, has knowledge of and is in compliance with the guidelines of the Centers for Disease Control and Prevention concerning the prevention of transmission of infectious agents through safe and appropriate injection practices. **http://www.cdc.gov/hicpac/2007IP/2007isolationPrecautions.html**	Y	05/05/2013
Have you surrendered your state or federal controlled substance registration or had it revoked or restricted in any way?	N	05/05/2013

Question	Response	Date
Have you had hospital staff privileges denied, suspended, limited, revoked or not renewed by the hospital, including any and all resignations from any medical staff in lieu of disciplinary or administrative action? If the answer is " Yes," type the name of the hospital, the hospital's mailing address, the type of action taken, and the date or dates of the actions taken in the textbox directly below this question. **(Please Note: Do not include suspensions or restrictions for failure to complete hospital medical records, attend hospital department or staff meetings, or maintain required malpractice insurance.)**	N	05/05/2013
Have you actively practiced medicine in Nevada within the past 12 months?	N	05/05/2013

Question	Response	Date
Explanation 14: For the above question if your answer is "NO" for the time period July 1, 2011 - June 30, 2013, or since your last renewal, please type your explanation in this text box.		05/05/2013
I hereby request my license to be placed on Inactive status, which means I will not physically practice in the state of Nevada. If you choose to place your license on Inactive status, make certain to select "Yes" to this question **AND** choose the Inactive status in the dropdown box located at the end of the questions.	N	05/05/2013

Question	Response	Date
The submission of the in-office surgery/procedure forms is required for all medical doctors, whether in state, out of state, active or inactive status! THIS IS NOT OPTIONAL. DO NOT answer this attestation until you have completed the requisite form. Once you have completed this action, you may proceed in answering the renewal attestations and questions. The online renewal site will retain your previous responses. Please go to the website, click on the following link for instructions and complete the required form.Click on the following link for the instructions and forms: http://medboard.nv.gov/New_In_Office_Surgery_Forms.htm **If you have submitted your In-Office Surgery/Procedure Reporting Forms (A/B forms) to the Board and are in compliance with NRS 630.30665, your answer should be "YES".**Nevada Revised Statutes (NRS) require the Nevada State Board of Medical Examiners to obtain from each applicant who seeks renewal of his or her license to practice medicine, a report stating the number and type of surgeries requiring conscious sedation, deep sedation or general anesthesia performed by the holder of the license at his or her office or any other facility, excluding any surgical care performed at a medical facility as defined in NRS 449.0151, or outside the state of Nevada.I hereby attest that I am in compliance with the reporting requirements of NRS 630.30665, and am aware that failure to submit a report or filing false information in a report is grounds for disciplinary action under Nevada`s Medical Practice Act.	Y	05/05/2013
Are you out of compliance with court ordered child support? **If this does not apply to you, please answer "no".** If "Yes" during the time period July 1, 2011 - June 30, 2013 type an explanation in the textbox directly below this question.	N	05/05/2013

Question	Response	Date
I have completed the required amount of AMA Category 1 CME within the current biennial. I understand that I may be included in a random audit. I agree to retain CME's taken between July 1, 2011 and June 30, 2013. (Review CME information online at www.medboard.nv.gov) If renewing to an Inactive status, CME is not required and "No" can be selected.	Y	05/05/2013
I SWEAR OR AFFIRM UNDER THE PENALTY OF PERJURY THAT I PERSONALLY ANSWERED ALL OF THE QUESTIONS IN THIS APPLICATION AND THAT THE ANSWERS I HAVE PROVIDED ARE TRUE AND CORRECT.	Y	05/05/2013

PHYSICIAN
APPLICATION FOR STATUS CHANGE AND/OR REINSTATEMENT TO ACTIVE OR INACTIVE STATUS - REGISTRATION FOR THE BIENNIAL REGISTRATION PERIOD 2007- 2009
NEVADA STATE BOARD OF MEDICAL EXAMINERS
Post Office Box 7238 Reno, Nevada 89510 Phone (775) 688-2559
Physical Address: 1105 Terminal Way, Suite 301 Reno, NV 89502

Date Received by Board
RECEIVED
NOV 26 2007
NEVADA STATE BOARD OF MEDICAL EXAMINERS

License No. 6314
File No. ____ (For Board Use Only)

I hereby apply for status change or reinstatement to active or inactive status, and enclose the appropriate fee as indicated below:

__✓__ CHANGE FROM INACTIVE TO ACTIVE STATUS $ 800.00 if during 7/1/2007 - 6/30/2008
$ 400.00 if during 7/1/2008 - 6/30/2009
_______ REINSTATEMENT TO ACTIVE STATUS $1,600.00
_______ REINSTATEMENT TO INACTIVE STATUS $ 800.00 (Inactive reinstatement, No CME's required)

Make checks payable to:
NEVADA STATE BOARD OF MEDICAL EXAMINERS
(Foreign checks must indicate "U.S. FUNDS")

PLEASE NOTE:

- THIS *APPLICATION FOR STATUS CHANGE AND/OR REINSTATEMENT TO ACTIVE STATUS REGISTRATION* FORM IS THE FORM TO BE COMPLETED FOR CHANGE OF STATUS AND/OR REINSTATEMENT TO ACTIVE STATUS MEDICAL LICENSURE IN THE STATE OF NEVADA.
- YOUR STATUS WILL NOT BE CHANGED AND/OR YOU WILL NOT BE REINSTATED UNLESS YOU ANSWER ALL QUESTIONS ON THIS *APPLICATION FOR STATUS CHANGE AND/OR REINSTATEMENT TO ACTIVE STATUS REGISTRATION* FORM. YOU MUST PROVIDE WRITTEN EXPLANATIONS FOR ALL QUESTIONS ANSWERED "YES."
- ALL INFORMATION YOU PROVIDE ON THIS *APPLICATION FOR STATUS CHANGE AND/OR REINSTATEMENT TO ACTIVE STATUS REGISTRATION* FORM IS PUBLIC INFORMATION.

PLEASE TYPE OR PRINT LEGIBLY

1. Active status registration requires the submission of proof of completion of 40 hours of AMA Category 1 continuing medical education (CME), which includes 2 hours of CME in medical ethics, 20 hours of CME in your scope of practice or specialty and 18 hours of CME in any other AMA Category 1 course - **completed during the preceding 24-month time period of the date of your submission of this form.** Submit your proof of completion of CME with your completed *APPLICATION FOR STATUS CHANGE AND/OR REINSTATEMENT TO ACTIVE STATUS REGISTRATION* form. (See last page of this form for CME statement.)

2. If your name and/or address has changed from that printed on the label on this form, clearly indicate the change in the space provided below. Please be advised, the address you indicate below is viewable on the NSBME website and is listed as the public address. Also, please indicate your current public telephone and fax numbers. [Please note: if your name has changed, please provide a notarized or certified copy of the document authorizing your name change (marriage license, divorce decree, etc.) must be included.]

Name STEPHEN L. GABRIEL ROTHMAN
Street 9233 W. PICO BLVD #210
City LOS Angeles County Los Angeles State CA Zip 90035
Phone Number 310-278-7642 Fax Number 310 859-2373
Email address ____

3. **IF YOU HAVE RETIRED OR MOVED YOUR PRACTICE,** indicate the location of patient records below:

Name ____
Street ____
City ____ County ____ State ____ Zip ____
Phone Number ____

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4. Indicate below your primary and secondary scopes of practice using the following codes:

SCOPES OF PRACTICE CODES

1 ADDICTION MEDICINE
2 ADOLESCENT MEDICINE
3 AEROSPACE MEDICINE
4 ALLERGY
5 ALLERGY/IMMUNOLOGY
6 AMBULATORY MEDICINE
7 ANESTHESIOLOGY
8 BLOODBANKING
9 BRONCO-ESOPHAGOLOGY
10 CARDIOVASCULAR DISEASES
11 CATSCAN/ULTRASOUND
12 CHILD NEUROLOGY
13 CHILD PSYCHIATRY
14 CLINICAL PHARMACOLOGY
15 CRITICAL CARE
16 DERMATOLOGY
17 DERMATOPATHOLOGY
18 EMERGENCY MEDICINE
19 ENDOCRINOLOGY
20 FAMILY PRACTICE
21 GASTROENTEROLOGY
22 GENERAL PRACTICE
23 GERIATRIC PSYCHIATRY
24 GERIATRICS
25 GYNECOLOGY
26 HAIR TRANSPLANTATION
27 HEMATOLOGY
28 HOMEOPATHY
29 HYPNOSIS
30 IMMUNOLOGY
31 INFECTIOUS DISEASES
32 INFERTILITY
33 INTERNAL MEDICINE
34 LARYNGOLOGY
35 LEGAL MEDICINE
36 MATERNAL/FETAL MEDICINE
37 MEDICAL ACUPUNCTURE
38 MEDICAL ETHICS
39 MEDICAL GENETICS
40 NEO/PERINATAL MEDICINE
41 NEOPLASTIC DISEASES
42 NEPHROLOGY
43 NEUROLOGY
44 NEURO-OPHTHALMOLOGY
45 NEUROPATHOLOGY
46 NEURORADIOLOGY
47 NON-CONVENTIONAL MEDICINE
48 NUCLEAR MEDICINE
49 NUTRITION
50 OBSTETRICS
51 OBSTETRICS/GYNECOLOGY
52 OCCUPATIONAL MEDICINE
53 ONCOLOGY
54 ONCOLOGY, GYNECOLOGICAL
55 ONCOLOGY, HEMATOLOGY
56 ONCOLOGY, RADIATION
57 ONCOLOGY, SURGICAL
58 OPHTHALMOLOGY
59 OTOLARYNGOLOGY
60 OTOLOGY
61 PAIN MANAGEMENT
62 PATHOLOGY
63 PATHOLOGY, ANATOMIC
64 PATHOLOGY, CLINICAL
65 PATHOLOGY, FORENSIC
66 PEDIATRIC, ALLERGY
67 PEDIATRIC, CARDIOLOGY
68 PEDIATRIC, CRITICAL CARE
69 PEDIATRIC, EMERGENCY MEDICINE
70 PEDIATRIC, ENDOCRINOLOGY
71 PEDIATRIC, GASTROENTEROLOGY
72 PEDIATRIC, HEMATOLOGY/ONCOLOGY
73 PEDIATRIC, INFECTIOUS DISEASES
74 PEDIATRIC, INTENSIVIST
75 PEDIATRIC, NEPHROLOGY
76 PEDIATRIC, NEUROLOGY
77 PEDIATRIC, OPHTHALMOLOGY
78 PEDIATRIC, PHYSIATRY
79 PEDIATRIC, PULMONARY
80 PEDIATRIC, RADIOLOGY
81 PEDIATRIC, RHEUMATOLOGY
82 PEDIATRIC, SURGERY
83 PEDIATRIC, UROLOGY
84 PEDIATRICS
85 PHYSICAL MEDICINE/REHABILITATION
86 PREVENTIVE MEDICINE
87 PSYCHIATRY
88 PSYCHOANALYSIS
89 PUBLIC HEALTH
90 PSYCHOMATIC MEDICINE
91 PULMONARY DISEASES
92 RADIOLOGY
93 RADIOLOGY, DIAGNOSTIC
94 RADIOLOGY, INTERVENTIONAL
95 RADIOLOGY, NUCLEAR
96 RADIOLOGY, THERAPEUTIC
97 RADIOLOGY, VASCULAR
98 RHEUMATOLOGY
99 RHINOLOGY
100 SLEEP DISORDERS
101 SPORTS MEDICINE
102 SURGERY, ABDOMINAL
103 SURGERY, CARDIOTHORACIC
104 SURGERY, CARDIOVASCULAR
105 SURGERY, COLON/RECTAL
106 SURGERY, GENERAL
107 SURGERY, HAND
108 SURGERY, HEAD/NECK
109 SURGERY, MAXILLOFACIAL
110 SURGERY, NEUROLOGICAL
111 SURGERY, ORTHOPEDIC
112 SURGERY, PLASTIC
113 SURGERY, THORACIC
114 SURGERY, TRANSPLANT
115 SURGERY, TRAUMATIC
116 SURGERY, UROLOGIC
117 SURGERY, VASCULAR
118 TOXICOLOGY
119 URGENT CARE
120 UROLOGY

Primary Scope of Practice **Code** 46

Secondary Scope of Practice **Code** 93

All of the following questions refer to the preceding 24-month time period of the date of your submission of this form.

For the purposes of the following questions, these phrases or words have these meanings:

"Ability to practice medicine" is to be construed to include all of the following:

1. The cognitive capacity to make appropriate clinical diagnoses and exercise reasoned medical judgments and to learn and keep abreast of medical developments;
2. The ability to communicate those judgments and medical information to patients and other health care providers, with or without the use of aids or devices, such as voice amplifiers; and
3. The physical capability to perform medical tasks such as physician examination and surgical procedures, with or without the use of aids or devices, such as corrective lenses or hearing aids.

"Medical condition" includes physiological, mental or psychological conditions or disorders, such as, but not limited to, orthopedic, vision, speech, hearing, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, emotional or mental illness, HIV disease, tuberculosis, drug addiction, and alcoholism.

"Chemical substances" is to be construed to include alcohol, drugs or medications, including those taken pursuant to a valid prescription for legitimate medical purposes and in accordance with the prescriber's direction.

FOR ALL "YES" RESPONSES TO THE FOLLOWING QUESTIONS, YOU MUST SUBMIT YOUR WRITTEN EXPLANATION(S) ON A SEPARATE SHEET ATTACHED TO YOUR COMPLETED *APPLICATION FOR STATUS CHANGE AND/OR REINSTATEMENT TO ACTIVE STATUS REGISTRATION* FORM.

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1. Do you have a medical condition which in any way impairs or limits your ability to practice medicine with reasonable skill and safety? ______Yes ___✓___No

2. If you have a medical condition which in any way impairs or limits your ability to practice medicine, is that impairment or limitation reduced or ameliorated because of the field of practice, the setting or the manner in which you have chosen to practice? ______Yes ___✓___No

3. If you use chemical substances, does your use in any way impair or limit your ability to practice medicine with reasonable skill and safety? ______Yes ___✓___No

4. Have you failed to initiate the performance of public service within one year after the date the public service is required to begin to satisfy a requirement of your receiving a loan or scholarship from the federal government or a state or local government for your medical education? ______Yes ___✓___No

5. Have you been a defendant in a legal action involving professional liability (malpractice) or had a professional liability claim paid in your behalf or paid such a claim yourself? ______Yes ___✓___No

6. Have you been investigated for, arrested, charged with, convicted of, or plead guilty or nolo contendere to any offense or violation of any federal (including the U.S. Military), state or local law, including any foreign country, which is in a foreign jurisdiction equivalent to, a misdemeanor, gross misdemeanor, court martial, or felony, excluding any minor traffic offense (driving or being in control of a motor vehicle while under the influence of any chemical substance and/or including alcohol, is not considered a minor traffic offense), or for any offense which is related to the manufacture, distribution, prescribing, or dispensing of controlled substances? Please note that you MUST disclose ANY investigation or arrest even if the ultimate disposition was dismissal or expungement. ______Yes ___✓___No

7. Have you ever been denied a license, permission to practice medicine or any other healing art, or permission to take an examination to practice medicine or any other healing art in any state, country or U.S. territory? ______Yes ___✓___No

8. Have you ever had a medical license or license to practice any other healing art revoked, suspended, limited, or restricted in any state, country or U.S. territory? ______Yes ___✓___No

9. Have you ever voluntarily surrendered a license to practice medicine or any other healing art in any state, country or U.S. territory? ______Yes ___✓___No

10. Have you ever been denied membership or expelled from a medical society or other professional medical organization? ______Yes ___✓___No

11. Have you ever been: a) notified that you were under investigation for; b) investigated for; c) charged with; or d) convicted of any violation of a statute, rule or regulation governing your practice as a physician by any medical licensing board, hospital, medical society, governmental entity or other agency <u>other than</u> the Nevada State Board of Medical Examiners? ______Yes ___✓___No

12. Have you ever surrendered your state or federal controlled substance registration or had it revoked or restricted in any way? ______Yes ___✓___No

13. List all hospitals where you have had staff privileges denied, suspended, limited, revoked or not renewed by the hospital. List any and all resignations from any medical staff in lieu of disciplinary or administrative action. (<u>Please Note</u>: Do not include suspensions or restrictions for failure to complete hospital medical records, attend hospital department or staff meetings, or maintain required malpractice insurance).

Hospital	Mailing Address	Type of Action	Dates of Action From (Mo./Yr.) To (Mo./Yr.)
–			

(If more space is needed, attach a separate sheet.)

OTHER STATES OF CURRENT PREVIOUS LICENSURE

List any and all licenses (including training licenses and permits) YOU HOLD OR HAVE HELD to practice medicine in any state, territory.

State/Territory	License #	Date of Issuance	Dates of Practice From (Mo./Yr.) To (Mo./Yr.)
CALIFORNIA			
ARIZONA			
HAWAII			

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CHILD SUPPORT STATEMENT

Please place a check mark next to one of the following statements:

✓ (a) I am not subject to a court order for the support of a child;

______ (b) I am subject to a court order for the support of one or more children and am in compliance with the order or am in compliance with a plan approved by the district attorney or other public agency enforcing the order for the repayment of the amount owed pursuant to the order; **OR**

______ (c) I am subject to a court order for the support of one or more children and am NOT in compliance with the order or a plan approved by the district attorney or other public agency enforcing the order for the repayment of the amount owed pursuant to the order.

CONTINUING MEDICAL EDUCATION (CME) STATEMENT

Please place a check mark next to one of the following statements:

✓ (a) I completed a minimum of 40 hours of AMA Category 1 continuing medical education (CME), 2 hours of which were in medical ethics and 20 hours of which were in my scope of practice or specialty during the past biennial period of July 1, 2005 through June 30, 2007;

______ (b) I was initially licensed in Nevada during the time period January 1, 2005 through June 30, 2006, the second six months of the past biennial period, and completed a minimum of 30 hours of AMA Category 1 continuing medical education (CME), 2 hours of which were in medical ethics and 20 hours of which were in my scope of practice or specialty;

______ (c) I was initially licensed in Nevada during the time period July 1, 2006 through December 31, 2006, the third six months of the past biennial period, and completed a minimum of 24 hours of AMA Category 1 continuing medical education (CME), 2 hours of which were in medical ethics and 18 hours of which were in my scope of practice or specialty;

______ (d) I was initially licensed in Nevada during the time period January 1, 2007 through June 30, 2007, the fourth six months of the past biennial period, and completed a minimum of 14 hours of AMA Category 1 continuing medical education (CME), 2 hours of which were in medical ethics and 8 hours of which were in my scope of practice or specialty, OR

______ (e) I am exempt from submitting proof of completion of continuing medical education (CME) because I have completed a full year of residency or fellowship training during the biennial period July 1, 2005 through June 30, 2007.

- **ATTACH COPIES OF PROOF OF YOUR COMPLETION OF CONTINUING MEDICAL EDUCATION (CME) HOURS.**
- **YOUR COPIES OF PROOF OF CME OR TRAINING COMPLETION WILL NOT BE RETURNED TO YOU.**

BY SIGNING ON THE SIGNATURE LINE BELOW:

I HEREBY REPRESENT THAT I AM THE PERSON NAMED IN THIS *APPLICATION FOR STATUS CHANGE AND/OR REINSTATEMENT TO ACTIVE STATUS REGISTRATION* OF LICENSE TO PRACTICE MEDICINE IN THE STATE OF NEVADA AND THAT ALL STATEMENTS I HAVE MADE HEREIN ARE TRUE;

1) **I UNDERSTAND THAT THIS *APPLICATION FOR STATUS CHANGE AND/OR REINSTATEMENT TO ACTIVE STATUS REGISTRATION* WILL BE DENIED IF I HAVE NOT PLACED A CHECK MARK NEXT TO (a), (b), OR (c) UNDER THE CHILD SUPPORT STATEMENT SECTION; AND**

2) **I UNDERSTAND THAT THIS *APPLICATION FOR STATUS CHANGE AND/OR REINSTATEMENT TO ACTIVE STATUS REGISTRATION* WILL BE DENIED IF I HAVE NOT ANSWERED ALL QUESTIONS THEREON AND/OR ATTACHED THERETO: (a) THE APPROPRIATE COPIES OF PROOF OF CONTINUING MEDICAL EDUCATION (CME); (b) PAYMENT OF THE APPROPRIATE FEE(S); AND (c) WRITTEN EXPLANATION(S) TO ANY "YES" ANSWER(S).**

11/18/07
Date

Signature (SIGNATURE STAMP UNACCEPTABLE)

STEPHEN L. G. ROTHMAN, M.D.

9233 W. Pico Blvd., Suite 210 · Los Angeles, CA 90035
Board Certified Radiologist with CAQ in Neuroradiology
(310) 278-7643 · (310) 278-7645 Fax

February 5, 2008

RECEIVED
APR 08 2008
NEVADA STATE BOARD OF MEDICAL EXAMINERS

Nevada State Board of Medical Examiners
Attn: Stephanie Weaver
P.O. Box 7238
Reno, NV 89510

ADDENDUM TO THE APPLICATION FOR BRINGING MY LICENSE TO ACTIVE STATUS

You have requested a list of all licenses held including license number, date of issuance and dates of practice.

STATE	NUMBER	ISSUED	STATUS
Hawaii	MD8851	7/28/94	Never practiced
Arizona	19993	4/26/91	Never practiced
Connecticut	013714	11/20/68	Expired 9/1981
California	G46280	10/5/81	Present
Florida	ME27089	09/20/76	Never practiced
Virginia	0101021283	07/01/71	*Never renewed

*Virginia does not have an exact expiration date. Normally M.D. licenses expire after two years in an "even" numbered year. They will not list an expiration date on any requests.

Sincerely yours,

Stephen L. G. Rothman, M.D.

SLGR:ts

Addendum to Status Change Application Rothman, M.D.

PHYSICIAN
APPLICATION FOR REGISTRATION RENEWAL
FOR THE BIENNIAL REGISTRATION PERIOD 2005 - 2007
NEVADA STATE BOARD OF MEDICAL EXAMINERS

Post Office Box 7238 Reno, Nevada 89510 Phone (775) 688-2559
Physical Address: 1105 Terminal Way, Suite 301 Reno, Nevada 89502

Date Received Board
JUN 27 2005
(For Board Use Only)

License No. 6314

File No. 9/20/91

I hereby apply for renewal of biennial registration and enclose the appropriate fee(s) as indicated below:

✓ INACTIVE STATUS $300.00 ...(*INACTIVE STATUS DOES NOT PERMIT THE PRACTICE OF MEDICINE INCLUDING THE WRITING OF PRESCRIPTIONS IN NEVADA)*

____ I REQUEST NON-RENEWAL OF MY LICENSE*

(*IF YOU ARE REQUESTING NON-RENEWAL, SEE BELOW)

File No: License No: 6314

Stephen L Gabriel ROTHMAN M.D.
9233 W Pico Blvd #210
Los Angeles CA 90035-

Make checks payable to:
NEVADA STATE BOARD OF MEDICAL EXAMINERS
(Foreign checks must indicate "U.S. FUNDS")

Request for NON-RENEWAL of License to Practice Medicine In Nevada

I hereby represent that I am the person named in this *APPLICATION FOR REGISTRATION RENEWAL* of license to practice medicine in the state of Nevada.

By signing on the signature line below, I am requesting that my license to practice medicine in Nevada NOT be renewed by the Nevada State Board of Medical Examiners. I will return this signed form to the board office.

__________ ____________________
Date Signature **(SIGNATURE STAMP UNACCEPTABLE)**

PLEASE NOTE:

- **YOUR CURRENT M.D. LICENSE EXPIRES ON JUNE 30, 2005. COMPLETED *APPLICATION FOR REGISTRATION RENEWAL* FORMS NOT RECEIVED AT THE BOARD OFFICE BY JULY 1, 2005 AT 5:00 P.M. ARE AUTOMATICALLY SUSPENDED FOR NON-PAYMENT. EXTENSIONS OF TIME ARE NOT ALLOWED FOR ANY REASON, AS NEVADA HAS NO GRACE PERIOD. (USE THE ENCLOSED ENVELOPE TO MAIL YOUR COMPLETED *APPLICATION FOR REGISTRATION RENEWAL* FORM.)**
- **YOUR LICENSE WILL NOT BE RENEWED UNLESS YOU ANSWER ALL QUESTIONS ON THIS *APPLICATION FOR REGISTRATION RENEWAL* FORM. YOU MUST PROVIDE WRITTEN EXPLANATIONS FOR ALL QUESTIONS ANSWERED "YES."**
- **ALL INFORMATION YOU PROVIDE ON THIS *APPLICATION FOR REGISTRATION RENEWAL* FORM IS PUBLIC INFORMATION.**

PLEASE TYPE OR PRINT LEGIBLY

1. If your name and/or address has changed from that printed on the label on this form, clearly indicate the change in the space provided below. Also, please indicate your current telephone and fax numbers. [Please note: a notarized or certified copy of the document authorizing your name change (marriage license, divorce decree, etc.) must be included.]

Name__________
Street__________
City______ County______ State______ Zip______
Phone Number 310 278-7683 Fax Number______

JUN 30 2005

2. **IF YOU HAVE RETIRED OR MOVED YOUR PRACTICE,** indicate the location of patient records below:

Name__________
Street__________
City______ County______ State______ Zip______
Phone Number______

3. Indicate below your primary and sec[ond]ary scopes of practice using the following [cod]es:

SCOPES OF PRACTICE CODES

Code	Scope	Code	Scope	Code	Scope
1	ADDICTION MEDICINE	41	NEOPLASTIC DISEASES	81	PEDIATRIC, RHEUMATOLOGY
2	ADOLESCENT MEDICINE	42	NEPHROLOGY	82	PEDIATRIC, SURGERY
3	AEROSPACE MEDICINE	43	NEUROLOGY	83	PEDIATRIC, UROLOGY
4	ALLERGY	44	NEURO-OPHTHALMOLOGY	84	PEDIATRICS
5	ALLERGY/IMMUNOLOGY	45	NEUROPATHOLOGY	85	PHYSICAL MEDICINE/REHABILITATION
6	AMBULATORY MEDICINE	46	NEURORADIOLOGY	86	PREVENTIVE MEDICINE
7	ANESTHESIOLOGY	47	NON-CONVENTIONAL MEDICINE	87	PSYCHIATRY
8	BLOODBANKING	48	NUCLEAR MEDICINE	88	PSYCHOANALYSIS
9	BRONCO-ESOPHAGOLOGY	49	NUTRITION	89	PUBLIC HEALTH
10	CARDIOVASCULAR DISEASES	50	OBSTETRICS	90	PSYCHOMATIC MEDICINE
11	CATSCAN/ULTRASOUND	51	OBSTETRICS/GYNECOLOGY	91	PULMONARY DISEASES
12	CHILD NEUROLOGY	52	OCCUPATIONAL MEDICINE	92	RADIOLOGY
13	CHILD PSYCHIATRY	53	ONCOLOGY	93	RADIOLOGY, DIAGNOSTIC
14	CLINICAL PHARMACOLOGY	54	ONCOLOGY, GYNECOLOGICAL	94	RADIOLOGY, INTERVENTIONAL
15	CRITICAL CARE	55	ONCOLOGY, HEMATOLOGY	95	RADIOLOGY, NUCLEAR
16	DERMATOLOGY	56	ONCOLOGY, RADIATION	96	RADIOLOGY, THERAPEUTIC
17	DERMATOPATHOLOGY	57	ONCOLOGY, SURGICAL	97	RADIOLOGY, VASCULAR
18	EMERGENCY MEDICINE	58	OPHTHALMOLOGY	98	RHEUMATOLOGY
19	ENDOCRINOLOGY	59	OTOLARYNGOLOGY	99	RHINOLOGY
20	FAMILY PRACTICE	60	OTOLOGY	100	SLEEP DISORDERS
21	GASTROENTEROLOGY	61	PAIN MANAGEMENT	101	SPORTS MEDICINE
22	GENERAL PRACTICE	62	PATHOLOGY	102	SURGERY, ABDOMINAL
23	GERIATRIC PSYCHIATRY	63	PATHOLOGY, ANATOMIC	103	SURGERY, CARDIOTHORACIC
24	GERIATRICS	64	PATHOLOGY, CLINICAL	104	SURGERY, CARDIOVASCULAR
25	GYNECOLOGY	65	PATHOLOGY, FORENSIC	105	SURGERY, COLON/RECTAL
26	HAIR TRANSPLANTATION	66	PEDIATRIC, ALLERGY	106	SURGERY, GENERAL
27	HEMATOLOGY	67	PEDIATRIC, CARDIOLOGY	107	SURGERY, HAND
28	HOMEOPATHY	68	PEDIATRIC, CRITICAL CARE	108	SURGERY, HEAD/NECK
29	HYPNOSIS	69	PEDIATRIC, EMERGENCY MEDICINE	109	SURGERY, MAXILLOFACIAL
30	IMMUNOLOGY	70	PEDIATRIC, ENDOCRINOLOGY	110	SURGERY, NEUROLOGICAL
31	INFECTIOUS DISEASES	71	PEDIATRIC, GASTROENTEROLOGY	111	SURGERY, ORTHOPEDIC
32	INFERTILITY	72	PEDIATRIC, HEMATOLOGY/ONCOLOGY	112	SURGERY, PLASTIC
33	INTERNAL MEDICINE	73	PEDIATRIC, INFECTIOUS DISEASES	113	SURGERY, THORACIC
34	LARYNGOLOGY	74	PEDIATRIC, INTENSIVIST	114	SURGERY, TRANSPLANT
35	LEGAL MEDICINE	75	PEDIATRIC, NEPHROLOGY	115	SURGERY, TRAUMATIC
36	MATERNAL/FETAL MEDICINE	76	PEDIATRIC, NEUROLOGY	116	SURGERY, UROLOGIC
37	MEDICAL ACUPUNCTURE	77	PEDIATRIC, OPHTHALMOLOGY	117	SURGERY, VASCULAR
38	MEDICAL ETHICS	78	PEDIATRIC, PHYSIATRY	118	TOXICOLOGY
39	MEDICAL GENETICS	79	PEDIATRIC, PULMONARY	119	URGENT CARE
40	NEO/PERINATAL MEDICINE	80	PEDIATRIC, RADIOLOGY	120	UROLOGY

Code **Code**

Primary Scope of Practice 92 **Secondary Scope of Practice** ______

All of the following questions refer to the time period July 1, 2003, through the present date only.

For the purposes of the following questions, these phrases or words have these meanings:

"Ability to practice medicine" is to be construed to include all of the following:

1. The cognitive capacity to make appropriate clinical diagnoses and exercise reasoned medical judgments and to learn and keep abreast of medical developments;
2. The ability to communicate those judgments and medical information to patients and other health care providers, with or without the use of aids or devices, such as voice amplifiers; and
3. The physical capability to perform medical tasks such as physician examination and surgical procedures, with or without the use of aids or devices, such as corrective lenses or hearing aids.

"Medical condition" includes physiological, mental or psychological conditions or disorders, such as, but not limited to, orthopedic, vision, speech, hearing, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, emotional or mental illness, HIV disease, tuberculosis, drug addiction, and alcoholism.

"Chemical substances" is to be construed to include alcohol, drugs or medications, including those taken pursuant to a valid prescription for legitimate medical purposes and in accordance with the prescriber's direction.

FOR ALL "YES" RESPONSES TO THE FOLLOWING QUESTIONS, YOU MUST SUBMIT YOUR WRITTEN EXPLANATION(S) ON A SEPARATE SHEET ATTACHED TO YOUR COMPLETED *APPLICATION FOR REGISTRATION RENEWAL* FORM.

1. Do you have a medical condition which in any way impairs or limits your ability to practice medicine with reasonable skill and safety? _______Yes ___✓___No

2. If you have a medical condition which in any way impairs or limits your ability to practice medicine, is that impairment or limitation reduced or ameliorated because of the field of practice, the setting, or the manner in which you have chosen to practice? ______Yes ______No ___✓___N/A

3. If you use chemical substances, does your use in any way impair or limit your ability to practice medicine with reasonable skill and safety? ______Yes ___✓___No _____N/A

4. Have you failed to initiate the performance of public service within one year after the date the public service is required to begin to satisfy a requirement of your receiving a loan or scholarship from the federal government or a state or local government for your medical education? ______Yes ___✓___No _____N/A

5. Have you been a defendant in a legal action involving professional liability (malpractice) or had a professional liability claim paid in your behalf or paid such a claim yourself? _______Yes ___✓___No

6. Have you ever been investigated for, charged with, convicted of, or plead guilty or nolo contendere to any offense or violation of any federal, state or local law, including any foreign country, which is a misdemeanor, gross misdemeanor, or felony, excluding any minor traffic offense (driving or in control of a motor vehicle while under the influence of any chemical substance is **not** considered **a minor traffic offense**) or which is related to the manufacture, distribution, prescribing, or dispensing of controlled substances? _______Yes ___✓___No

7. Have you ever been denied a license, permission to practice medicine or any other healing art, or permission to take an examination to practice medicine or any other healing art in any state, country or U.S. territory? _______Yes ___✓___No

8. Have you ever had a medical license or license to practice any other healing art revoked, suspended, limited, or restricted in any state, country or U.S. territory? _______Yes ___✓___No

9. Have you ever voluntarily surrendered a license to practice medicine or any other healing art in any state, country or U.S. territory? _______Yes ___✓___No

10. Have you ever been denied membership or expelled from a medical society or other professional medical organization? _______Yes ___✓___No

11. Have you ever been: a) notified that you were under investigation for; b) investigated for; c) charged with; or d) convicted of any violation of a statute, rule or regulation governing your practice as a physician by any medical licensing board, hospital, medical society, governmental entity or other agency <u>other than</u> the Nevada State Board of Medical Examiners? _______Yes ___✓___No

12. Have you ever surrendered your state or federal controlled substance registration or had it revoked or restricted in any way? _______Yes ___✓___No

13. List all hospitals where you have had staff privileges denied, suspended, limited, revoked or not renewed by the hospital. List any and all resignations from any medical staff in lieu of disciplinary or administrative action. (<u>Please Note</u>: Do not include suspensions or restrictions for failure to complete hospital medical records, attend hospital department or staff meetings, or maintain required malpractice insurance.)

Hospital	Mailing Address	Type of Action	Dates of Action From (Mo./Yr.) To (Mo./Yr.)
—			

(If more space is needed, attach a separate sheet.)

CHILD SUPPORT STATEMENT

Please place a check mark next to one of the following statements:

__✓__ (a) I am not subject to a court order for the support of a child;

______ (b) I am subject to a court order for the support of one or more children and am in compliance with the order or am in compliance with a plan approved by the district attorney or other public agency enforcing the order for the repayment of the amount owed pursuant to the order; **OR**

______ (c) I am subject to a court order for the support of one or more children and am NOT in compliance with the order or a plan approved by the district attorney or other public agency enforcing the order for the repayment of the amount owed pursuant to the order.

I HAVE _____ HAVE NOT __✓__ ***(CHECK ONE)*** ACTIVELY PRACTICED MEDICINE IN NEVADA WITHIN THE PAST 12 MONTHS.

BY SIGNING ON THE SIGNATURE LINE BELOW:

1) **I HEREBY REPRESENT THAT I AM THE PERSON NAMED IN THIS *APPLICATION FOR REGISTRATION RENEWAL* OF LICENSE TO PRACTICE MEDICINE IN THE STATE OF NEVADA AND THAT ALL STATEMENTS I HAVE MADE HEREIN ARE TRUE;**

2) **I UNDERSTAND THAT THIS *APPLICATION FOR REGISTRATION RENEWAL* WILL BE DENIED IF I HAVE NOT PLACED A CHECK MARK NEXT TO (a), (b), OR (c) UNDER THE CHILD SUPPORT STATEMENT SECTION;**

3) **I UNDERSTAND THAT THIS *APPLICATION FOR REGISTRATION RENEWAL* WILL BE DENIED IF I HAVE NOT ANSWERED ALL QUESTIONS THEREON AND/OR ATTACHED THERETO PAYMENT OF THE APPROPRIATE REGISTRATION RENEWAL FEE AND WRITTEN EXPLANATION(S) TO ANY "YES" ANSWER(S);**

4) **I UNDERSTAND THAT BY REGISTERING IN INACTIVE STATUS, I MAY NOT PRACTICE MEDICINE IN THE STATE OF NEVADA, AND THAT THE PRACTICE OF MEDICINE INCLUDES THE WRITING OF PRESCRIPTIONS; AND**

5) **I UNDERSTAND THAT AN INACTIVE STATUS LICENSEE IN NEVADA MUST MEET STATUTORY REQUIREMENTS TO CHANGE TO ACTIVE STATUS, AND A CHANGE TO ACTIVE STATUS REQUIRES SPECIFIC FORMAL APPROVAL BY THE NEVADA STATE BOARD OF MEDICAL EXAMINERS.**

6/20/05
Date

Signature **(SIGNATURE STAMP UNACCEPTABLE)**

PHYSICIAN
APPLICATION FOR REGISTRATION RENEWAL
FOR THE BIENNIAL REGISTRATION PERIOD 2003- 2005
NEVADA STATE BOARD OF MEDICAL EXAMINERS
Post Office Box 7238 Reno, Nevada 89510 Phone (775) 688-2559
Physical Address: 1105 Terminal Way, Suite 301 Reno, Nevada 89502

Date Received by Board
JUN 5 2003
MAY 2 7 2003
(For Board Use Only)

License No. 6314 6314

File No.________

I hereby apply for renewal of biennial registration and enclose the appropriate fee(s) as indicated below:

________ACTIVE STATUS	$400.00	
✓ INACTIVE STATUS	$200.00 ✓	*(INACTIVE STATUS DOES NOT PERMIT THE PRACTICE OF MEDICINE INCLUDING THE WRITING OF PRESCRIPTIONS IN NEVADA)*
________I REQUEST NON-RENEWAL OF MY LICENSE* (*IF YOU ARE REQUESTING NON-RENEWAL, SEE BELOW)		

File no: License no: 6314

Stephen L ROTHMAN M.D.
9233 W Pico Blvd #210
Los Angeles CA 90035

Make checks payable to:
NEVADA STATE BOARD OF MEDICAL EXAMINERS
(Foreign checks must indicate "U.S. FUNDS")

Request for NON-RENEWAL of License to Practice Medicine In Nevada

I hereby represent that I am the person named in this *APPLICATION FOR REGISTRATION RENEWAL* of license to practice medicine in the state of Nevada.

By signing on the signature line below, I am requesting that my license to practice medicine in Nevada NOT be renewed by the Nevada State Board of Medical Examiners. I will return this signed form to the board office.

Date________ Signature **(SIGNATURE STAMP UNACCEPTABLE)**

PLEASE NOTE:

- **YOUR CURRENT M.D. LICENSE EXPIRES ON JUNE 30, 2003. COMPLETED *APPLICATION FOR REGISTRATION RENEWAL* FORMS NOT RECEIVED AT THE BOARD OFFICE BY JULY 1, 2003 AT 5:00 P.M. ARE AUTOMATICALLY SUSPENDED FOR NON-PAYMENT. EXTENSIONS OF TIME ARE NOT ALLOWED FOR ANY REASON, AS NEVADA HAS NO GRACE PERIOD. (USE THE ENCLOSED ENVELOPE TO MAIL YOUR COMPLETED *APPLICATION FOR REGISTRATION RENEWAL* FORM.)**
- **YOUR LICENSE WILL NOT BE RENEWED UNLESS YOU ANSWER ALL QUESTIONS ON THIS *APPLICATION FOR REGISTRATION RENEWAL* FORM. YOU MUST PROVIDE WRITTEN EXPLANATIONS FOR ALL QUESTIONS ANSWERED "YES."**
- **ALL INFORMATION YOU PROVIDE ON THIS *APPLICATION FOR REGISTRATION RENEWAL* FORM IS PUBLIC INFORMATION.**

PLEASE TYPE OR PRINT LEGIBLY

1. Active status registration renewal requires the submission of proof of completion of 40 hours of AMA Category 1 continuing medical education (CME), which includes 2 hours of CME in medical ethics and 20 hours of CME in your scope of practice or specialty **completed during the period July 1, 2001 through June 30, 2003**. Submit your proof of completion of CME with your completed *Application for Registration Renewal* form. (See last page of this form for CME statement.)

2. If your name and/or address has changed from that printed on the label on this form, clearly indicate the change in the space provided below. Also, please indicate your current telephone and fax numbers. [Please note: a notarized or certified copy of the document authorizing your name change (marriage license, divorce decree, etc.) must be included.]

Name________

Street________

City________ County________ State________ Zip________

Phone Number________ Fax Number________

3. **IF YOU HAVE RETIRED OR MOVED YOUR PRACTICE,** indicate the location of patient records below:

Name________

Street________

City________ County________ State________ Zip________

Phone Number________

4. Indicate below your primary and secondary scopes of practice using the following codes:

SCOPES OF PRACTICE CODES

1 ADDICTION MEDICINE
2 ADOLESCENT MEDICINE
3 AEROSPACE MEDICINE
4 ALLERGY
5 ALLERGY/IMMUNOLOGY
6 AMBULATORY MEDICINE
7 ANESTHESIOLOGY
8 BLOODBANKING
9 BRONCO-ESOPHAGOLOGY
10 CARDIOVASCULAR DISEASES
11 CATSCAN/ULTRASOUND
12 CHILD NEUROLOGY
13 CHILD PSYCHIATRY
14 CLINICAL PHARMACOLOGY
15 CRITICAL CARE
16 DERMATOLOGY
17 DERMATOPATHOLOGY
18 EMERGENCY MEDICINE
19 ENDOCRINOLOGY
20 FAMILY PRACTICE
21 GASTROENTEROLOGY
22 GENERAL PRACTICE
23 GERIATRIC PSYCHIATRY
24 GERIATRICS
25 GYNECOLOGY
26 HAIR TRANSPLANTATION
27 HEMATOLOGY
28 HOMEOPATHY
29 HYPNOSIS
30 IMMUNOLOGY
31 INFECTIOUS DISEASES
32 INFERTILITY
33 INTERNAL MEDICINE
34 LARYNGOLOGY
35 LEGAL MEDICINE
36 MATERNAL/FETAL MEDICINE
37 MEDICAL ACUPUNCTURE
38 MEDICAL ETHICS
39 MEDICAL GENETICS
40 NEO/PERINATAL MEDICINE
41 NEOPLASTIC DISEASES
42 NEPHROLOGY
43 NEUROLOGY
44 NEURO-OPHTHALMOLOGY
45 NEUROPATHOLOGY
46 NEURORADIOLOGY
47 NON-CONVENTIONAL MEDICINE
48 NUCLEAR MEDICINE
49 NUTRITION
50 OBSTETRICS
51 OBSTETRICS/GYNECOLOGY
52 OCCUPATIONAL MEDICINE
53 ONCOLOGY
54 ONCOLOGY, GYNECOLOGICAL
55 ONCOLOGY, HEMATOLOGY
56 ONCOLOGY, RADIATION
57 ONCOLOGY, SURGICAL
58 OPHTHALMOLOGY
59 OTOLARYNGOLOGY
60 OTOLOGY
61 PAIN MANAGEMENT
62 PATHOLOGY
63 PATHOLOGY, ANATOMIC
64 PATHOLOGY, CLINICAL
65 PATHOLOGY, FORENSIC
66 PEDIATRIC, ALLERGY
67 PEDIATRIC, CARDIOLOGY
68 PEDIATRIC, CRITICAL CARE
69 PEDIATRIC, EMERGENCY MEDICINE
70 PEDIATRIC, ENDOCRINOLOGY
71 PEDIATRIC, GASTROENTEROLOGY
72 PEDIATRIC, HEMATOLOGY/ONCOLOGY
73 PEDIATRIC, INFECTIOUS DISEASES
74 PEDIATRIC, INTENSIVIST
75 PEDIATRIC, NEPHROLOGY
76 PEDIATRIC, NEUROLOGY
77 PEDIATRIC, OPHTHALMOLOGY
78 PEDIATRIC, PHYSIATRY
79 PEDIATRIC, PULMONARY
80 PEDIATRIC, RADIOLOGY
81 PEDIATRIC, RHEUMATOLOGY
82 PEDIATRIC, SURGERY
83 PEDIATRIC, UROLOGY
84 PEDIATRICS
85 PHYSICAL MEDICINE/REHABILITATION
86 PREVENTIVE MEDICINE
87 PSYCHIATRY
88 PSYCHOANALYSIS
89 PUBLIC HEALTH
90 PSYCHOMATIC MEDICINE
91 PULMONARY DISEASES
92 RADIOLOGY
93 RADIOLOGY, DIAGNOSTIC
94 RADIOLOGY, INTERVENTIONAL
95 RADIOLOGY, NUCLEAR
96 RADIOLOGY, THERAPEUTIC
97 RADIOLOGY, VASCULAR
98 RHEUMATOLOGY
99 RHINOLOGY
100 SLEEP DISORDERS
101 SPORTS MEDICINE
102 SURGERY, ABDOMINAL
103 SURGERY, CARDIOTHORACIC
104 SURGERY, CARDIOVASCULAR
105 SURGERY, COLON/RECTAL
106 SURGERY, GENERAL
107 SURGERY, HAND
108 SURGERY, HEAD/NECK
109 SURGERY, MAXILLOFACIAL
110 SURGERY, NEUROLOGICAL
111 SURGERY, ORTHOPEDIC
112 SURGERY, PLASTIC
113 SURGERY, THORACIC
114 SURGERY, TRANSPLANT
115 SURGERY, TRAUMATIC
116 SURGERY, UROLOGIC
117 SURGERY, VASCULAR
118 TOXICOLOGY
119 URGENT CARE
120 UROLOGY

Primary Scope of Practice Code: 93

Secondary Scope of Practice Code: ________

All of the following questions refer to the time period July 1, 2001, through the present date only.

For the purposes of the following questions, these phrases or words have these meanings:

"Ability to practice medicine" is to be construed to include all of the following:

1. The cognitive capacity to make appropriate clinical diagnoses and exercise reasoned medical judgments and to learn and keep abreast of medical developments;
2. The ability to communicate those judgments and medical information to patients and other health care providers, with or without the use of aids or devices, such as voice amplifiers; and
3. The physical capability to perform medical tasks such as physician examination and surgical procedures, with or without the use of aids or devices, such as corrective lenses or hearing aids.

"Medical condition" includes physiological, mental or psychological conditions or disorders, such as, but not limited to, orthopedic, vision, speech, hearing, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, emotional or mental illness, HIV disease, tuberculosis, drug addiction, and alcoholism.

"Chemical substances" is to be construed to include alcohol, drugs or medications, including those taken pursuant to a valid prescription for legitimate medical purposes and in accordance with the prescriber's direction.

FOR ALL "YES" RESPONSES TO THE FOLLOWING QUESTIONS, YOU MUST SUBMIT YOUR WRITTEN EXPLANATION(S) ON A SEPARATE SHEET ATTACHED TO YOUR COMPLETED *APPLICATION FOR REGISTRATION RENEWAL* FORM.

1. Do you have a medical condition which in any way impairs or limits your ability to practice medicine with reasonable skill and safety? _______Yes ___✓___No

2. If you have a medical condition which in any way impairs or limits your ability to practice medicine, is that impairment or limitation reduced or ameliorated because of the field of practice, the setting, or the manner in which you have chosen to practice? ______Yes ___✓___No _____N/A

3. If you use chemical substances, does your use in any way impair or limit your ability to practice medicine with reasonable skill and safety? ______Yes______No ___✓___N/A

4. Have you failed to initiate the performance of public service within one year after the date the public service is required to begin to satisfy a requirement of your receiving a loan or scholarship from the federal government or a state or local government for your medical education? ______Yes _______No___✓___N/A

5. Have you been a defendant in a legal action involving professional liability (malpractice) or had a professional liability claim paid in your behalf or paid such a claim yourself? ______Yes ___✓___No

6. Have you ever been investigated for, charged with, convicted of, or plead guilty or nolo contendere to any offense or violation of any federal, state or local law, including any foreign country, which is a misdemeanor, gross misdemeanor, or felony, excluding any minor traffic offense (driving or in control of a motor vehicle while under the influence of any chemical substance is **not** considered **a minor traffic offense**) or which is related to the manufacture, distribution, prescribing, or dispensing of controlled substances? _______Yes ___✓___No

7. Have you ever been denied a license, permission to practice medicine or any other healing art, or permission to take an examination to practice medicine or any other healing art in any state, country or U.S. territory? _______Yes ___✓___No

8. Have you ever had a medical license or license to practice any other healing art revoked, suspended, limited, or restricted in any state, country or U.S. territory? _______Yes ___✓___No

9. Have you ever voluntarily surrendered a license to practice medicine or any other healing art in any state, country or U.S. territory? _______Yes___✓___No

10. Have you ever been denied membership or expelled from a medical society or other professional medical organization? _______Yes ___✓___No

11. Have you ever been: a) notified that you were under investigation for; b) investigated for; c) charged with; or d) convicted of any violation of a statute, rule or regulation governing your practice as a physician by any medical licensing board, hospital, medical society, governmental entity or other agency <u>other than</u> the Nevada State Board of Medical Examiners? _______Yes ___✓___No

12. Have you ever surrendered your state or federal controlled substance registration or had it revoked or restricted in any way? _______Yes___✓___No

13. List all hospitals where you have had staff privileges denied, suspended, limited, revoked or not renewed by the hospital. List any and all resignations from any medical staff in lieu of disciplinary or administrative action. (<u>Please Note</u>: Do not include suspensions or restrictions for failure to complete hospital medical records, attend hospital department or staff meetings, or maintain required malpractice insurance).

Hospital	Mailing Address	Type of Action	Dates of Action From (Mo./Yr.) To (Mo./Yr.)

(If more space is needed, attach a separate sheet.)

CHILD SUPPORT STATEMENT

Please place a check mark next to one of the following statements:

✓ (a) I am not subject to a court order for the support of a child;

______ (b) I am subject to a court order for the support of one or more children and am in compliance with the order or am in compliance with a plan approved by the district attorney or other public agency enforcing the order for the repayment of the amount owed pursuant to the order; **OR**

______ (c) I am subject to a court order for the support of one or more children and am NOT in compliance with the order or a plan approved by the district attorney or other public agency enforcing the order for the repayment of the amount owed pursuant to the order.

CONTINUING MEDICAL EDUCATION (CME) STATEMENT

Please place a check mark next to one of the following statements:

✓ (a) I completed a minimum of 40 hours of AMA Category 1 continuing medical education (CME), 2 hours of which were in medical ethics and 20 hours of which were in my scope of practice or specialty, during the past biennial period of July 1, 2001 through June 30, 2003;

______ (b) I was initially licensed in Nevada during the time period January 1, 2002 through June 30, 2002, the second six months of the past biennial period, and completed a minimum of 30 hours of AMA Category I continuing medical education (CME), 2 hours of which were in medical ethics and 20 hours of which were in my scope of practice or specialty;

______ (c) I was initially licensed in Nevada during the time period July 1, 2002 through December 31, 2002, the third six months of the past biennial period, and completed a minimum of 20 hours of AMA Category I continuing medical education (CME), 2 hours of which were in medical ethics and 18 hours of which were in my scope of practice or specialty;

______ (d) I was initially licensed in Nevada during the time period January 1, 2003 through June 30, 2003, the fourth six months of the past biennial period, and completed a minimum of 10 hours of AMA Category I continuing medical education (CME), 2 hours of which were in medical ethics and 8 hours of which were in my scope of practice or specialty; **OR**

______ (e) I am exempt from submitting proof of completion of continuing medical education (CME) because I have completed a full year of residency or fellowship training during the biennial period July 1, 2001 through June 30, 2003.

- **ATTACH COPIES OF PROOF OF YOUR COMPLETION OF CONTINUING MEDICAL EDUCATION (CME) HOURS.**
- **IF YOU COMPLETED A FULL YEAR OF RESIDENCY OR FELLOWSHIP TRAINING DURING THE BIENNIAL PERIOD JULY 1, 2001 THROUGH JUNE 30, 2003, ATTACH A COPY OF PROOF OF COMPLETION OF YOUR TRAINING.**
- **YOUR COPIES OF PROOF OF CME OR TRAINING COMPLETION WILL NOT BE RETURNED TO YOU.**

I HAVE____ HAVE NOT ✓ ***(CHECK ONE)*** ACTIVELY PRACTICED MEDICINE IN NEVADA WITHIN THE PAST 12 MONTHS.

BY SIGNING ON THE SIGNATURE LINE BELOW:

1) **I HEREBY REPRESENT THAT I AM THE PERSON NAMED IN THIS *APPLICATION FOR REGISTRATION RENEWAL* OF LICENSE TO PRACTICE MEDICINE IN THE STATE OF NEVADA AND THAT ALL STATEMENTS I HAVE MADE HEREIN ARE TRUE;**
2) **I UNDERSTAND THAT THIS *APPLICATION FOR REGISTRATION RENEWAL* WILL BE DENIED IF I HAVE NOT PLACED A CHECK MARK NEXT TO (a), (b), OR (c) UNDER THE CHILD SUPPORT STATEMENT SECTION; AND**
3) **I UNDERSTAND THAT THIS *APPLICATION FOR REGISTRATION RENEWAL* WILL BE DENIED IF I HAVE NOT ANSWERED ALL QUESTIONS THEREON AND/OR ATTACHED THERETO: (a) THE APPROPRIATE COPIES OF PROOF OF CONTINUING MEDICAL EDUCATION (CME), OR RESIDENCY OR FELLOWSHIP TRAINING COMPLETION; (b) PAYMENT OF THE APPROPRIATE REGISTRATION RENEWAL FEE; AND (c) WRITTEN EXPLANATION(S) TO ANY "YES" ANSWER(S).**

5/7/03

Date

Signature (SIGNATURE STAMP UNACCEPTABLE)

PHYSICIAN
APPLICATION FOR REGISTRATION RENEWAL
FOR THE BIENNIAL REGISTRATION PERIOD 2001-2003
NEVADA STATE BOARD OF MEDICAL EXAMINERS

Post Office Box 7238 Reno, Nevada 89510 Phone (775) 688-2559

Date Received by Board
MAY 29 2001
(For Board Use Only)

License No. 6314

File No.

I hereby apply for renewal of biennial registration and enclose the appropriate fee(s) as indicated below:

X ACTIVE STATUS	$600.00	
___ INACTIVE STATUS	$200.00	*(RETIRED STATUS REQUIRES THAT THE*
___ RETIRED STATUS	$ 50.00	*APPLICANT NOT PRACTICE MEDICINE*
___ SUPERVISING/COLLABORATING PHYSICIAN	$200.00	*ANYWHERE)*

9-20-91

file no: [redacted] candidate no: 3718[redacted]
Stephen L ROTHMAN M.D.
8501 Wilshire Blvd.
Beverly Hills, CA 90211

Make checks payable to:
NEVADA STATE BOARD OF MEDICAL EXAMINERS
(Foreign checks must indicate "U.S. FUNDS")

PLEASE NOTE:

- **YOUR CURRENT M.D. LICENSE EXPIRES ON JUNE 30, 2001. COMPLETED *APPLICATION FOR REGISTRATION RENEWAL* FORMS NOT RECEIVED AT THE BOARD OFFICE BY JULY 1, 2001 AT 5:00 P.M. ARE AUTOMATICALLY SUSPENDED FOR NON-PAYMENT. EXTENSIONS OF TIME ARE NOT ALLOWED FOR ANY REASON, AS NEVADA HAS NO GRACE PERIOD. (USE THE ENCLOSED ENVELOPE TO MAIL YOUR COMPLETED *APPLICATION FOR REGISTRATION RENEWAL* FORM.)**
- **YOUR LICENSE WILL NOT BE RENEWED UNLESS YOU ANSWER ALL QUESTIONS ON THIS *APPLICATION FOR REGISTRATION RENEWAL* FORM. YOU MUST PROVIDE WRITTEN EXPLANATIONS FOR ALL QUESTIONS ANSWERED "YES."**
- **ALL INFORMATION YOU PROVIDE ON THIS *APPLICATION FOR REGISTRATION RENEWAL* FORM IS PUBLIC INFORMATION.**

PLEASE TYPE OR PRINT LEGIBLY

1. To be eligible to act as a **SUPERVISING PHYSICIAN FOR A PHYSICIAN ASSISTANT**, and/or as a **COLLABORATING PHYSICIAN FOR AN ADVANCED PRACTITIONER OF NURSING** for the biennial period of July 1, 2001 through June 30, 2003, you must complete the enclosed ***Application for Approval as Supervising/Collaborating Physician*** and return it with your payment in the amount of $200.00 in the enclosed envelope.

2. Active status registration renewal requires the submission of proof of completion of 40 hours of AMA Category 1 continuing medical education (CME), which includes 2 hours of CME in medical ethics and 20 hours of CME in your scope of practice or specialty **completed during the period July 1, 1999 through June 30, 2001**. Submit your proof of completion of CME with your completed *Application for Registration Renewal* form. (See last page of this form for CME statement.)

3. If your name and/or address has changed from that printed on the label on this form, clearly indicate the change in the space provided below. Also, please indicate your current telephone and fax numbers. [Please note: a notarized or certified copy of the document authorizing your name change (marriage license, divorce decree, etc.) must be included.]

Name Stephen L. G. Rothman, M.D.
Street 9233 W. Pico Blvd., Suite 210
City Los Angeles County Los Angeles State CA Zip 90035
Phone Number 310-278-7643 Fax Number 310-278-7644

4. **IF YOU HAVE RETIRED OR MOVED YOUR PRACTICE,** indicate the location of patient records below:

Name ______
Street ______
City ______ County ______ State ______ Zip ______
Phone Number ______

5. Indicate below the **EXACT NAME AND LOCATION** of the Medical School from which you graduated and your **EXACT DATE** of graduation:

Albert Einstein College of Medicine - Bronx, NY — 2 June 1967

Medical School Name and Location — Date of Graduation (Month / Day / Year)

6. Indicate below your primary, secondary and tertiary practice specialties using the following codes:

SCOPE OF PRACTICE SPECIALTY CODES

1 ADDICTION MEDICINE
2 ADOLESCENT MEDICINE
3 AEROSPACE MEDICINE
4 ALLERGY
5 ALLERGY/IMMUNOLOGY
6 ANESTHESIOLOGY
7 BLOODBANKING
8 BRONCO-ESOPHAGOLOGY
9 CARDIOVASCULAR DISEASES
10 CATSCAN/ULTRASOUND
11 CHILD NEUROLOGY
12 CHILD PSYCHIATRY
13 CLINICAL PHARMACOLOGY
14 CRITICAL CARE
15 DERMATOLOGY
16 DERMATOPATHOLOGY
17 EMERGENCY MEDICINE
18 ENDOCRINOLOGY
19 FAMILY PRACTICE
20 GASTROENTEROLOGY
21 GENERAL PRACTICE
22 GERIATRICS
23 GYNECOLOGY
24 HEMATOLOGY
25 HOMEOPATHY
26 HYPNOSIS
27 IMMUNOLOGY
28 INFECTIOUS DISEASES
29 INFERTILITY
30 INTERNAL MEDICINE
31 LARYNGOLOGY
32 LEGAL MEDICINE
33 MATERNAL/FETAL MEDICINE
34 MEDICAL ACUPUNCTURE
35 MEDICAL ETHICS
36 MEDICAL GENETICS
37 NEO/PERINATAL MEDICINE
38 NEOPLASTIC DISEASES
39 NEPHROLOGY
40 NEUROLOGY
41 NEURO-OPHTHALMOLOGY
42 NEUROPATHOLOGY
43 NEURORADIOLOGY
44 NON-CONVENTIONAL MEDICINE
45 NUCLEAR MEDICINE
46 NUTRITION
47 OBSTETRICS
48 OBSTETRICS/GYNECOLOGY
49 OCCUPATIONAL MEDICINE
50 ONCOLOGY
51 ONCOLOGY, GYNECOLOGICAL
52 ONCOLOGY, HEMATOLOGY
53 ONCOLOGY, RADIATION
54 ONCOLOGY, SURGICAL
55 OPHTHALMOLOGY
56 OTOLARYNGOLOGY
57 OTOLOGY
58 PAIN MANAGEMENT
59 PATHOLOGY
60 PATHOLOGY, ANATOMIC
61 PATHOLOGY, CLINICAL
62 PATHOLOGY, FORENSIC
63 PEDIATRIC, ALLERGY
64 PEDIATRIC, CARDIOLOGY
65 PEDIATRIC, CRITICAL CARE
66 PEDIATRIC, EMERGENCY MEDICINE
67 PEDIATRIC, ENDOCRINOLOGY
68 PEDIATRIC, GASTROENTEROLOGY
69 PEDIATRIC, HEMATOLOGY/ONCOLOGY
70 PEDIATRIC, INFECTIOUS DISEASES
71 PEDIATRIC, INTENSIVIST
72 PEDIATRIC, NEPHROLOGY
73 PEDIATRIC, NEUROLOGY
74 PEDIATRIC, OPHTHALMOLOGY
75 PEDIATRIC, PHYSIATRY
76 PEDIATRIC, PULMONARY
77 PEDIATRIC, RADIOLOGY
78 PEDIATRIC, SURGERY
79 PEDIATRIC, UROLOGY
80 PEDIATRICS
81 PHYSICAL MEDICINE/REHABILITATION
82 PREVENTIVE MEDICINE
83 PSYCHIATRY
84 PSYCHOANALYSIS
85 PSYCHOMATIC MEDICINE
86 PUBLIC HEALTH
87 PULMONARY DISEASES
88 RADIOLOGY
89 RADIOLOGY, DIAGNOSTIC
90 RADIOLOGY, INTERVENTIONAL
91 RADIOLOGY, NUCLEAR
92 RADIOLOGY, THERAPEUTIC
93 RADIOLOGY, VASCULAR
94 RHEUMATOLOGY
95 RHINOLOGY
96 SLEEP DISORDERS
97 SPORTS MEDICINE
98 SURGERY, ABDOMINAL
99 SURGERY, CARDIOTHORACIC
100 SURGERY, CARDIOVASCULAR
101 SURGERY, COLON/RECTAL
102 SURGERY, GENERAL
103 SURGERY, HAND
104 SURGERY, HEAD/NECK
105 SURGERY, MAXILLOFACIAL
106 SURGERY, NEUROLOGICAL
107 SURGERY, ORTHOPEDIC
108 SURGERY, PLASTIC
109 SURGERY, THORACIC
110 SURGERY, TRANSPLANT
111 SURGERY, TRAUMATIC
112 SURGERY, UROLOGIC
113 SURGERY, VASCULAR
114 URGENT CARE
115 UROLOGY

	Code		Code		Code
Primary Specialty	89	**Secondary Specialty**	43	**Tertiary Specialty**	

//

All of the following questions refer to the time period July 1, 1999, through the present date only.

For the purposes of the following questions, these phrases or words have these meanings:

"Ability to practice medicine" is to be construed to include all of the following:

1. The cognitive capacity to make appropriate clinical diagnoses and exercise reasoned medical judgments and to learn and keep abreast of medical developments;
2. The ability to communicate those judgments and medical information to patients and other health care providers, with or without the use of aids or devices, such as voice amplifiers; and
3. The physical capability to perform medical tasks such as physician examination and surgical procedures, with or without the use of aids or devices, such as corrective lenses or hearing aids.

"Medical condition" includes physiological, mental or psychological conditions or disorders, such as, but not limited to, orthopedic, vision, speech, hearing, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, emotional or mental illness, HIV disease, tuberculosis, drug addiction, and alcoholism.

"Chemical substances" is to be construed to include alcohol, drugs or medications, including those taken pursuant to a valid prescription for legitimate medical purposes and in accordance with the prescriber's direction.

FOR ALL "YES" RESPONSES TO THE FOLLOWING QUESTIONS, YOU MUST SUBMIT YOUR WRITTEN EXPLANATION(S) ON A SEPARATE SHEET ATTACHED TO YOUR COMPLETED *APPLICATION FOR REGISTRATION RENEWAL* FORM.

1. Do you have a medical condition which in any way impairs or limits your ability to practice medicine with reasonable skill and safety? _______Yes ___✓___No

2. If you have a medical condition which in any way impairs or limits your ability to practice medicine, is that impairment or limitation reduced or ameliorated because of the field of practice, the setting, or the manner in which you have chosen to practice? ______Yes _____No __✓__N/A

3. If you use chemical substances, does your use in any way impair or limit your ability to practice medicine with reasonable skill and safety? ______Yes______No __✓__N/A

4. Have you failed to initiate the performance of public service within one year after the date the public service is required to begin to satisfy a requirement of your receiving a loan or scholarship from the federal government or a state or local government for your medical education? ______Yes _______No__✓__N/A

5. Have you been a defendant in a legal action involving professional liability (malpractice) or had a professional liability claim paid in your behalf or paid such a claim yourself? ______Yes ___✓___No

6. Have you ever been investigated for, charged with, convicted of, or plead guilty or nolo contendere to any offense or violation of any federal, state or local law, including any foreign country, which is a misdemeanor, gross misdemeanor, or felony, excluding any minor traffic offense (driving or in control of a motor vehicle while under the influence of any chemical substance is **not considered a minor traffic offense**) or which is related to the manufacture, distribution, prescribing, or dispensing of controlled substances? _______Yes ___✓___No

7. Have you ever been denied a license, permission to practice medicine or any other healing art, or permission to take an examination to practice medicine or any other healing art in any state, country or U.S. territory? _______Yes ___✓___No

8. Have you ever had a medical license or license to practice any other healing art revoked, suspended, limited, or restricted in any state, country or U.S. territory? _______Yes ___✓___No

9. Have you ever voluntarily surrendered a license to practice medicine or any other healing art in any state, country or U.S. territory? _______Yes___✓___No

10. Have you ever been denied membership or expelled from a medical society or other professional medical organization? _______Yes ___✓___No

11. Have you ever been: a) notified that you were under investigation for; b) investigated for; c) charged with; or d) convicted of any violation of a statute, rule or regulation governing your practice as a physician by any medical licensing board, hospital, medical society, governmental entity or other agency <u>other than</u> the Nevada State Board of Medical Examiners? _______Yes ___✓___No

12. Have you ever surrendered your state or federal controlled substance registration or had it revoked or restricted in any way? _______Yes___✓___No

13. List all hospitals where you have had staff privileges denied, suspended, limited, revoked or not renewed by the hospital. List any and all resignations from any medical staff in lieu of disciplinary or administrative action. (<u>Please Note</u>: Do not include suspensions or restrictions for failure to complete hospital medical records, attend hospital department or staff meetings, or maintain required malpractice insurance).

Hospital	Mailing Address	Type of Action	Dates of Action From (Mo./Yr.) To (Mo./Yr.)

(If more space is needed, attach a separate sheet.)

CHILD SUPPORT STATEMENT

Please place a check mark next to one of the following statements:

__✓__ (a) I am not subject to a court order for the support of a child;

______ (b) I am subject to a court order for the support of one or more children and am in compliance with the order or am in compliance with a plan approved by the district attorney or other public agency enforcing the order for the repayment of the amount owed pursuant to the order; **OR**

______ (c) I am subject to a court order for the support of one or more children and am NOT in compliance with the order or a plan approved by the district attorney or other public agency enforcing the order for the repayment of the amount owed pursuant to the order.

CONTINUING MEDICAL EDUCATION (CME) STATEMENT

lease place a check mark next to one of the following statements:

__✓__ (a) I completed a minimum of 40 hours of AMA Category 1 continuing medical education (CME), 2 hours of which were in medical ethics and 20 hours of which were in my scope of practice or specialty, during the past biennial period of July 1, 1999 through June 30, 2001;

______ (b) I was initially licensed in Nevada during the time period January 1, 2000 through June 30, 2000, the second six months of the past biennial period, and completed a minimum of 30 hours of AMA Category I continuing medical education (CME), 2 hours of which were in medical ethics and 20 hours of which were in my scope of practice or specialty;

______ (c) I was initially licensed in Nevada during the time period July 1, 2000 through December 31, 2000, the third six months of the past biennial period, and completed a minimum of 20 hours of AMA Category I continuing medical education (CME), 2 hours of which were in medical ethics and 18 hours of which were in my scope of practice or specialty;

______ (d) I was initially licensed in Nevada during the time period January 1, 2001 through June 30, 2001, the fourth six months of the past biennial period, and completed a minimum of 10 hours of AMA Category I continuing medical education (CME), 2 hours of which were in medical ethics and 8 hours of which were in my scope of practice or specialty; **OR**

______ (e) I am exempt from submitting proof of completion of continuing medical education (CME) because I have completed a full year of residency or fellowship training during the biennial period July 1, 1999 through June 30, 2001.

- **ATTACH COPIES OF PROOF OF YOUR COMPLETION OF CONTINUING MEDICAL EDUCATION (CME) HOURS.**
- **IF YOU COMPLETED A FULL YEAR OF RESIDENCY OR FELLOWSHIP TRAINING DURING THE BIENNIAL PERIOD JULY 1, 1999 THROUGH JUNE 30, 2001, ATTACH A COPY OF PROOF OF COMPLETION OF YOUR TRAINING.**
- **YOUR COPIES OF PROOF OF CME OR TRAINING COMPLETION WILL NOT BE RETURNED TO YOU.**

I HAVE____ HAVE NOT __✓__ ***(CHECK ONE)*** ACTIVELY PRACTICED MEDICINE IN NEVADA WITHIN THE PAST 12 MONTHS.

BY SIGNING ON THE SIGNATURE LINE BELOW:

1) **I HEREBY REPRESENT THAT I AM THE PERSON NAMED IN THIS *APPLICATION FOR REGISTRATION RENEWAL* OF LICENSE TO PRACTICE MEDICINE IN THE STATE OF NEVADA AND THAT ALL STATEMENTS I HAVE MADE HEREIN ARE TRUE;**
2) **I UNDERSTAND THAT THIS *APPLICATION FOR REGISTRATION RENEWAL* WILL BE DENIED IF I HAVE NOT PLACED A CHECK MARK NEXT TO (a), (b), OR (c) UNDER THE CHILD SUPPORT STATEMENT SECTION; AND**
3) **I UNDERSTAND THAT THIS *APPLICATION FOR REGISTRATION RENEWAL* WILL BE DENIED IF I HAVE NOT ANSWERED ALL QUESTIONS THEREON AND/OR ATTACHED THERETO: (a) THE APPROPRIATE COPIES OF PROOF OF CONTINUING MEDICAL EDUCATION (CME), OR RESIDENCY OR FELLOWSHIP TRAINING COMPLETION; (b) PAYMENT OF THE APPROPRIATE REGISTRATION RENEWAL FEE; AND (c) WRITTEN EXPLANATION(S) TO ANY "YES" ANSWER(S).**

5/20/01

Date   Signature (SIGNATURE STAMP UNACCEPTABLE)

PHYSICIAN
APPLICATION FOR RENEWAL REGISTRATION
NEVADA STATE BOARD OF MEDICAL EXAMINERS

Post Office Box 7238 Reno, Nevada 89510 Phone (775) 688-2559

Date Received by Board
JUN 21 1999
(Board Use Only)

License No.________
File No.________

I hereby apply for renewal of biennial registration and enclose the appropriate fee(s) as indicated below:

X	ACTIVE STATUS	$600.00
	INACTIVE STATUS	$200.00
	RETIRED STATUS	$ 50.00
	SUPERVISING/COLLABORATING PHYSICIAN	$200.00

Stephen L.G. Rothman, MD
8501 Wilshire Blvd.
Beverly Hills CA 90211

...e checks payable to:
...OARD OF MEDICAL EXAMINERS
...s must indicate "U.S. FUNDS")

PLEASE NOTE

NEVADA HAS NO GRACE PERIOD - - - - - LICENSES NOT RENEWED BY JULY 1, 1999 ARE AUTOMATICALLY SUSPENDED FOR NON-PAYMENT.
EXTENSIONS OF TIME ARE NOT ALLOWED FOR ANY REASON.
YOUR LICENSE WILL NOT BE RENEWED WITHOUT ANSWERING ALL QUESTIONS.
ALL YES ANSWERS MUST BE EXPLAINED.
YOU MUST INCLUDE PROOF OF 40 HOURS OF AMA CATEGORY 1 CME WHICH INCLUDES 2 HOURS IN MEDICAL ETHICS AND 20 HOURS IN YOUR SCOPE OF PRACTICE OR SPECIALTY.
ALL FEES MUST BE PAID AND ARE NON-REFUNDABLE.
DO NOT SEND CASH THROUGH THE MAIL.
PLEASE ALLOW SIXTY (60) DAYS FOR PROCESSING OF YOUR APPLICATION.

PLEASE TYPE OR PRINT LEGIBLY

1. **YOUR CURRENT M.D. LICENSE EXPIRES ON JUNE 30, 1999. THIS IS THE NOTICE TO RENEW YOUR M.D. LICENSE.**

2. To be eligible to act as a supervising physician for a physician's assistant, or as a collaborating physician for an advanced practitioner of nursing, complete the enclosed Application for Approval as Supervising/Collaborating Physician.

3. **ACTIVE STATUS REGISTRATION RENEWAL REQUIRES THE SUBMISSION OF PROOF OF 40 HOURS OF AMA CATEGORY 1 CONTINUING MEDICAL EDUCATION** which includes 2 hours of medical ethics and 20 hours in your scope of practice or specialty completed during the period July 1, 1997 through June 30, 1999. Submit your proof of CME with your completed Application for Registration Renewal form.

4. In order to provide sufficient time for processing, please complete and return your Application for Registration Renewal form and Application for Approval as Supervising/Collaborating Physician form (if applicable) with your proof of 40 hours AMA Category I CME and the correct fee(s) **BY JUNE 30, 1999.** Use the enclosed self-addressed envelope to return your completed form(s) and fee(s).

5. If your name and/or address has changed from that printed on this form, clearly indicate the change in the space provided. A notarized or certified copy of the document authorizing your name change (marriage license, divorce decree, etc.) must be included.

Name Stephen Rothman
Street 8501 Wilshire Blvd
City Beverly Hills County LA State CA Zip 90211

6. **IF YOU HAVE RETIRED OR MOVED YOUR PRACTICE, INDICATE THE LOCATION OF PATIENT RECORDS BELOW:**

Name________
Street________
City________ County________ State________ Zip________

7. Are you currently active in medic[illegible]?
a. [ ] YES, in training. b. [✓] YES, working full-time
c. [ ] YES, working part-time d. [ ] NO, retired.
e. [ ] NO, other (specify____)

8. Please indicate your primary, secondary and tertiary specialties and percent of practice time spent in each, using the following codes:

SCOPE OF PRACTICE
SPECIALTY CODES

Code	Specialty	Code	Specialty	Code	Specialty
102	ADDICTION MEDICINE	31	NEOPLASTIC DISEASES	62	PEDIATRIC, RADIOLOGY
1	ADOLESCENT MEDICINE	32	NEPHROLOGY	63	PEDIATRIC, SURGERY
2	AEROSPACE MEDICINE	33	NEUROLOGY	64	PEDIATRIC, UROLOGY
3	ALLERGY/IMMUNOLOGY	34	NEUROPATHOLOGY	65	PEDIATRICS
104	ALTERNATIVE MEDICINE	35	NEURORADIOLOGY	66	PHYSICAL MEDICINE/REHABILITATION
4	ANESTHESIOLOGY	36	NUCLEAR MEDICINE	67	PREVENTIVE MEDICINE
5	BLOODBANKING	37	NUTRITION	68	PSYCHIATRY
6	BRONCO-ESOPHAGOLOGY	38	OBSTETRICS/GYNECOLOGY	69	PSYCHOANALYSIS
7	CARDIOVASCULAR DISEASES	39	OBSTETRICS	70	PSYCHOMATIC MEDICINE
8	CATSCAN/ULTRASOUND	40	OCCUPATIONAL MEDICINE	71	PUBLIC HEALTH
9	CHILD NEUROLOGY	41	ONCOLOGY	72	PULMONARY DISEASES
10	CHILD PSYCHIATRY	45	ONCOLOGY, GYNECOLOGICAL	73	RADIOLOGY
11	CLINICAL PHARMACOLOGY	42	ONCOLOGY, HEMATOLOGY	(74)	RADIOLOGY, DIAGNOSTIC
12	CRITICAL CARE	43	ONCOLOGY, RADIATION	75	RADIOLOGY, NUCLEAR
13	DERMATOLOGY	44	ONCOLOGY, SURGICAL	76	RADIOLOGY, THERAPEUTIC
14	EMERGENCY MEDICINE	46	OPHTHALMOLOGY	77	RHEUMATOLOGY
15	ENDOCRINOLOGY	47	OTOLARYNGOLOGY	78	RHINOLOGY
16	FAMILY PRACTICE	48	OTOLOGY	79	SLEEP DISORDERS
17	GASTROENTEROLOGY	49	PAIN MANAGEMENT	100	SPORTS MEDICINE
18	GENERAL PRACTICE	50	PATHOLOGY	80	SURGERY, ABDOMINAL
19	GERIATRICS	51	PATHOLOGY, ANATOMIC	103	SURGERY, CARDIOTHORACIC
20	GYNECOLOGY	52	PATHOLOGY, CLINICAL	81	SURGERY, CARDIOVASCULAR
21	HEMATOLOGY	53	PATHOLOGY, FORENSIC	91	SURGERY, COLON/RECTAL
105	HOMEOPATHY	54	PEDIATRIC, ALLERGY	82	SURGERY, GENERAL
22	HYPNOSIS	55	PEDIATRIC, CARDIOLOGY	83	SURGERY, HAND
23	IMMUNOLOGY	99	PEDIATRIC, CRITICAL CARE	84	SURGERY, HEAD/NECK
24	INFECTIOUS DISEASES	97	PEDIATRIC, EMERGENCY MEDICINE	92	SURGERY, MAXILLOFACIAL
25	INFERTILITY	56	PEDIATRIC, ENDOCRINOLOGY	93	SURGERY, NEUROLOGICAL
26	INTERNAL MEDICINE	57	PEDIATRIC, HEMATOLOGY/ONCOLOGY	85	SURGERY, ORTHOPEDIC
27	LARYNGOLOGY	58	PEDIATRIC, INFECTIOUS DISEASES	86	SURGERY, PLASTIC
28	LEGAL MEDICINE	59	PEDIATRIC, INTENSIVIST	87	SURGERY, THORACIC
29	MATERNAL/FETAL MEDICINE	60	PEDIATRIC, NEPHROLOGY	88	SURGERY, TRAUMATIC
106	MEDICAL ACUPUNCTURE	98	PEDIATRIC, NEUROLOGY	89	SURGERY, UROLOGIC
107	MEDICAL ETHICS	101	PEDIATRIC, OPHTHALMOLOGY	90	SURGERY, VASCULAR
30	NEO/PERINATAL MEDICINE	61	PEDIATRIC, PHYSIATRY	94	UROLOGY
		95	PEDIATRIC, PULMONARY		

	Code	Percent of Time	Board Certified (Indicate Yes/No)
Primary	74	100	Y
Secondary			
Tertiary			

PLEASE INDICATE ALL AMERICAN BOARD OF MEDICAL SPECIALTIES BOARD OR SUBBOARD CERTIFICATIONS:

	Date of Initial Certification	Date of Last Certification
Board Am. B. Radiology	1973 (Mo./Yr.)	1973 (Mo./Yr.)
Subboard ________	(Mo./Yr.)	(Mo/Yr.)
Board ________	(Mo./Yr.)	(Mo./Yr.)
Subboard ________	(Mo./Yr.)	(Mo./Yr.)

9. Form of employment is 1001. (Use one of the following codes.)

SELF-EMPLOYED:
1001 Solo Practice
1002 Partnership or Group Practitioners

SALARIED, EMPLOYED BY:
1003 Individual Practitioner
1004 Partnership or Group of Practitioners
1005 Group Health Plan Facility (such as H.M.O.)

SALARIED, EMPLOYED BY: (continued)
1006 Other Non-Government Employer (hospital, school, etc.)
1007 Federal Government (armed services personnel only)
1008 Federal Government (civilian, P.H.S., etc.)
1009 State Government
1010 County Government
1011 Local Government

1012 Other (specify)________________________

All of the followi[illegible]g questions refer to t[illegible] time period July 1, 1997, through the present date only.

For the purposes of the following questions, these phrases or words have these meanings:

"Ability to practice medicine" is to be construed to include all of the following:

1. The cognitive capacity to make appropriate clinical diagnoses and exercise reasoned medical judgments and to learn and keep abreast of medical developments;
2. The ability to communicate those judgments and medical information to patients and other health care providers, with or without the use of aids or devices, such as voice amplifiers; and
3. The physical capability to perform medical tasks such as physician examination and surgical procedures, with or without the use of aids or devices, such as corrective lenses or hearing aids.

"Medical condition" includes physiological, mental or psychological conditions or disorders, such as, but not limited to, orthopedic, vision, speech, hearing, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, emotional or mental illness, HIV disease, tuberculosis, drug addiction, and alcoholism.

"Chemical substances" is to be construed to include alcohol, drugs or medications, including those taken pursuant to a valid prescription for legitimate medical purposes and in accordance with the prescriber's direction.

"Currently" does not mean on the day of, or even in the weeks or months preceding the completing of this application. Rather, it means recently enough so that the use of drugs may have an ongoing impact on one's functioning as a licensee.

FOR ALL "YES" RESPONSES TO THE FOLLOWING QUESTIONS, YOU MUST SUBMIT YOUR EXPLANATION(S) ON A SEPARATE SHEET ATTACHED TO YOUR COMPLETED REGISTRATION APPLICATION FORM

1. Do you have a medical condition which in any way impairs or limits your ability to practice medicine with reasonable skill and safety? _______Yes ___✓___No

2. If you have a medical condition which in any way impairs or limits your ability to practice medicine, is that impairment or limitation reduced or ameliorated because of the field of practice, the setting, or the manner in which you have chosen to practice? ______Yes ___✓___No ______N/A

3. If you use chemical substances, does your use in any way impair or limit your ability to practice medicine with reasonable skill and safety? ______Yes ___✓___No ______N/A

4. Have you failed to initiate the performance of public service within one year after the date the public service is required to begin to satisfy a requirement of your receiving a loan or scholarship from the federal government or a state or local government for your medical education? ______Yes ___✓___No ______N/A

5. Have you been a defendant in a legal action involving professional liability (malpractice) or had a professional liability claim paid in your behalf or paid such a claim yourself? ______Yes ___✓___No

6. Have you ever been investigated for, charged with, convicted of, or plead guilty or nolo contendere to any offense or violation of any federal, state or local law, including any foreign country, which is a misdemeanor, gross misdemeanor, or felony, excluding any minor traffic offense (driving or in control of a motor vehicle while under the influence of any chemical substance is **not** considered **a minor traffic offense**) or which is related to the manufacture, distribution, prescribing, or dispensing of controlled substances? _______Yes ___✓___No

7. Have you ever been denied a license, permission to practice medicine or any other healing art(s), or permission to take an examination to practice medicine or any other healing art(s) in any state, country or U.S. territory? _______Yes ___✓___No

8. Have you ever had a medical license or license to practice any other healing art revoked, suspended, limited, or restricted in any state, country or U.S. territory? _______Yes ___✓___No

9. Have you ever voluntarily surrendered a license to practice medicine or any other healing art in any state, country or U.S. territory? _______Yes ___✓___No

10. Have you ever been denied membership or expelled from a medical society or other professional medical organization? _______Yes ___✓___No

11. Have you ever been investigated for, charged with, or convicted of any violation of a statute, rule or regulation governing the practice of medicine by any medical licensing board, hospital, medical society, governmental entity or other agency?

_____Yes __✓__No

12. Have you ever surrendered your state or federal controlled substance registration or had it revoked or restricted in any way?

_____Yes __✓__No

13. List all hospitals where you have had staff privileges denied, suspended, limited, revoked or not renewed by the hospital. List any and all resignations from any medical staff in lieu of disciplinary or administrative action. (Please Note: Do not include suspensions or restrictions for failure to complete hospital medical records, attend hospital department or staff meetings, or maintain required malpractice insurance).

Hospital	Mailing Address	Type of Action	Dates of Action From (Mo./Yr.) To (Mo./Yr.)

(If more space is needed, attach a separate sheet.)

PLEASE CHECK ONE OF THE FOLLOWING:

__✓__ I am not subject to a court order for the support of a child.

_____ I am subject to a court order for the support of one or more children and am in compliance with the order or am in compliance with a plan approved by the district attorney or other public agency enforcing the order for the repayment of the amount owed pursuant to the order; or

_____ I am subject to a court order for the support of one or more children and am NOT in compliance with the order or a plan approved by the district attorney or other public agency enforcing the order for the repayment of the amount owed pursuant to the order.

Signature_______________________________ **(SIGNATURE STAMP UNACCEPTABLE)**

PLEASE CHECK ONE OF THE FOLLOWING:

__✓__ 1. I have earned a minimum of 40 hours approved AMA Category 1 continuing medical education (CME), 2 hours of which were in medical ethics, and 20 hours of which were in my scope of practice or specialty during the biennial period July 1, 1997, through June 30, 1999.

_____ 2. I was initially licensed in Nevada during the second six months of the biennial period July 1, 1997, through June 30, 1999, and have earned a minimum of 30 hours approved AMA Category I continuing medical education (CME).

_____ 3. I was initially licensed in Nevada during the third six months of the biennial period July 1, 1997, through June 30, 1999, and have earned a minimum of 20 hours approved AMA Category I continuing medical education (CME).

_____ 4. I was initially licensed in Nevada during the fourth six months of the biennial period July 1, 1997, through June 30, 1999, and have earned a minimum of 10 hours approved AMA Category I continuing medical education (CME).

_____ 5. I am exempt from submitting proof of continuing medical education (CME) because I have completed a full year of residency or fellowship training during the biennial period July 1, 1997, through June 30, 1999.

IMPORTANT

ATTACH COPIES OF PROOF OF DECLARED CME CREDITS - PROOF OF CME CREDITS WILL NOT BE RETURNED.

Signature_______________________________ **(SIGNATURE STAMP UNACCEPTABLE)**

I HAVE____ HAVE NOT __✓__ ACTIVELY PRACTICED IN NEVADA WITHIN THE PAST 12 MONTHS. (CHECK ONE)

I HEREBY CERTIFY THAT I AM THE PERSON NAMED IN THIS APPLICATION FOR REGISTRATION RENEWAL OF LICENSE TO PRACTICE MEDICINE IN THE STATE OF NEVADA AND THAT ALL STATEMENTS I HAVE MADE HEREIN ARE TRUE.

Business Telephone #	Date	Signature **(SIGNATURE STAMP UNACCEPTABLE)**
310 360 8930	6/16/99	

APPLICATION FOR RENEWAL REGISTRATION
NEVADA STATE BOARD OF
MEDICAL EXAMINERS
Post Office Box 7238 Reno, Nevada 89510 Phone (702) 688-2559

Date received by Board: RECEIVED JUL 25 1997 NEVADA STATE BOARD OF MEDICAL EXAMINERS (Board Use Only)

License No.______

File No.______

I hereby apply for renewal of biennial registration and enclose the appropriate fees as indicated below:

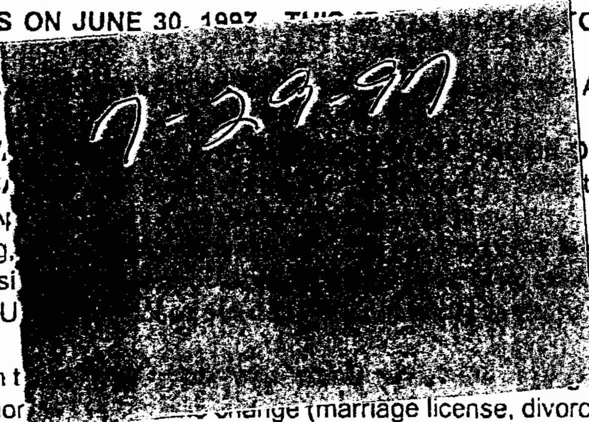
✓ ACTIVE STATUS $600.00✓
INACTIVE STATUS $150.00
RETIRED STATUS $ 50.00
P.A. SUPERVISING PHYSICIAN $200.00

PLEASE NOTE: NEVADA HAS NO GRACE PERIOD. LICENSES NOT RENEWED BY JULY 1, 1997 ARE AUTOMATICALL SUSPENDED FOR NON-PAYMENT

Steven Rothman, MD.
FAX# (310) 859-2373

Make checks payable to:
NEVADA STATE BOARD OF MEDICAL EXAMINERS
(Foreign checks must indicate "U.S. FUNDS")

INSTRUCTIONS - TYPE OR PRINT LEGIBLY



1. YOUR CURRENT M.D. LICENSE EXPIRES ON JUNE 30, 1997 [illegible] O RENEW YOUR M. LICENSE.
2. To be eligible to act as a supervising physicia[illegible] Application for Approv as Supervising Physician form.
3. ACTIVE STATUS REGISTRATION RENEW[illegible] OF 40 HOURS OF AM CATEGORY I, CONTINUING MEDICAL EDUC[illegible] through June 30, 19[illegible] Submit your proof of CME with your completed A[illegible]
4. In order to provide sufficient time for processing,[illegible] gistration Renewal fo and Application for Approval as Supervising Physi[illegible] s AMA Category I CM and the correct fee(s) **PRIOR TO JULY 1, 1997.** U[illegible] your completed form(and fee(s).
5. If your name and/or address has changed from t[illegible] in the space provide A notarized or certified copy of the document author[illegible] change (marriage license, divorce decree, etc.) must b included.

Name Stephen Rothman
Street 8501 Wilshire Blvd
City Beverly Hills County LA State CA Zip 90211

6. IF YOU HAVE RETIRED OR MOVED YOUR PRACTICE, PLEASE INDICATE THE LOCATION OF FORMER PATIEN RECORDS BELOW:

Name Stephen Rothman
Street 8501 Wilshire Blvd
City Bevely Hills County LA State CA Zip 90211

YOUR LICENSE REGISTRATION WILL NOT BE RENEWED WITHOUT SUBMISSION OF THE CORRECT FEE(S), PROPERLY COMPLETED FORM(S) AND PROOF OF 40 HOURS OF AMA CATEGORY I, CME'S

ALL PAGES OF THE FORM(S) MUST BE COMPLETED AND RETURNED

ALL FEES ARE NON-REFUNDABLE

DO NOT SEND CASH THROUGH THE MAIL

1. Are you currently active in medicine?
   - a. [ ] YES, in training.
   - b. [√] YES, working full-time
   - c. [ ] YES, working part-time
   - d. [ ] NO, retired.
   - e. [ ] NO, other (specify________________________________)

2. Please indicate your primary, secondary and tertiary specialties and percent of time spent in each, using the following codes.

SPECIALTY CODE:

1 ADOLESCENT MEDICINE
2 AEROSPACE MEDICINE
3 ALLERGY/IMMUNOLOGY
4 ANESTHESIOLOGY
5 BLOODBANKING
6 BRONCO-ESOPHAGOLOGY
7 CARDIOVASC DISEASES
8 CATSCAN/ULTRASOUND
9 CHILD NEUROLOGY
10 CHILD PSYCHIATRY
11 CLINICAL PHARMACOL
12 CRITICAL CARE
13 DERMATOLOGY
14 EMERGENCY MEDICINE
15 ENDOCRINOLOGY
16 FAMILY PRACTICE
17 GASTROENTEROLOGY
18 GENERAL PRACTICE
19 GERIATRICS
20 GYNECOLOGY
21 HEMATOLOGY
22 HYPNOSIS
23 IMMUNOLOGY
24 INFECTIOUS DISEASES
25 INFERTILITY
26 INTERNAL MEDICINE
27 LARYNGOLOGY
28 LEGAL MEDICINE
29 MATERNAL/FETAL MED
30 NEO/PERINATAL MED
31 NEOPLASTIC DISEASES
32 NEPHROLOGY
33 NEUROLOGY
34 NEUROPATHOLOGY
35 NEURORADIOLOGY
36 NUCLEAR MEDICINE
37 NUTRITION
38 OBSTETRIC/GYNECOLOGY
39 OBSTETRICS
40 OCCUPATIONAL MED
41 ONCOLOGY
45 ONCOLOGY, GYNECOLOGIC
42 ONCOLOGY, HEMATOLOGY
43 ONCOLOGY, RADIATION
44 ONCOLOGY, SURGICAL
45 OPHTHALMOLOGY
47 OTOLARYNGOLOGY
48 OTOLOGY
49 PAIN MANAGEMENT
50 PATHOLOGY
51 PATHOLOGY, ANATOMIC
52 PATHOLOGY, CLINICAL
53 PATHOLOGY FORENSIC
54 PED ALLERGY
55 PED CARDIOLOGY
99 PED CRITICAL CARE
97 PED EMERGENCY MED
56 PED. ENDOCRINOLOGY
57 PED. HEMAT/ONCOLOGY
58 PED. INFECTIOUS DIS
59 PED. INTENSIVIST
60 PED. NEPHROLOGY
98 PED. NEUROLOGY
101 PED OPHTHALMOLOGY
61 PED PHYSIATRY
95 PED PULMONARY
62 PED RADIOLOGY
63 PED SURGERY
64 PED UROLOGY
65 PEDIATRICS
66 PHYSICAL MED/REHAB
96 PHYSICIAN ASSISTANT
67 PREVENTIVE MED
68 PSYCHIATRY
69 PSYCHOANALYSIS
70 PSYCHOMATIC MEDICINE
71 PUBLIC HEALTH
72 PULMONARY DISEASES
73 RADIOLOGY
74 RADIOLOGY, DIAGNOSTIC
75 RADIOLOGY, NUCLEAR
76 RADIOLOGY, THERAPEUT
77 RHEUMATOLOGY
78 RHINOLOGY
79 SLEEP DISORDERS
100 SPORTS MEDICINE
80 SURGERY ABDOMINAL
81 SURGERY, CARDIOVASC
91 SURGERY, COLON/RECTAL
82 SURGERY, GENERAL
83 SURGERY, HAND
84 SURGERY, HEAD/NECK
92 SURGERY, MAXILLOFAC
93 SURGERY, NEUROLOGICAL
85 SURGERY, ORTHOPEDIC
86 SURGERY, PLASTIC
87 SURGERY, THORACIC
88 SURGERY TRAUMATIC
89 SURGERY, UROLOGIC
90 SURGERY, VASCULAR
94 UROLOGY

	Code	Percent of Time	Board Certified (Indicate Yes/No)
Primary	74	100	Yes
Secondary			
Tertiary			

PLEASE INDICATE AMERICAN BOARD OF MEDICAL SPECIALTIES BOARD CERTIFICATION:

		Date of Initial Certification	Date of Last Certification
Board	DIAGNOSTIC RADIOLOGY [signature]	June 1973 (Mo./Yr.)	— (Mo./Yr.)
Subboard	CAQ Neuroradiology	Nov 1995 (Mo./Yr.)	(Mo./Yr.)

3. Form of employment is 1002 (Use the following codes)

SELF-EMPLOYED
- 1001 Solo Practice
- 1002 Partnership or Group Practitioners

SALARIED, EMPLOYED BY:
- 1003 Individual Practitioner
- 1004 Partnership or Group of Practitioners
- 1005 Group Health Plan Facility (such as H.M.O.)

SALARIED, EMPLOYED BY (continued)
- 1006 Other Non-Government Employer (hospital, school, etc.)
- 1007 Federal Government (armed services personnel only)
- 1008 Federal Government (civilian, P.H.S., etc.)
- 1009 State Government
- 1010 County Government
- 1011 Local Government
- 1012 Other (specify)________________________

All of the following questions refer to the time period July 1, 1995, through the present date only.
FOR ALL YES RESPONSES, PLEASE EXPLAIN ON A SEPARATE SHEET AND RETURN WITH THIS REGISTRATION APPLICATION

For the purposes of the following questions, these phrases or words have these meanings:
"Ability to practice medicine" is to be construed to include all of the following:

1. The cognitive capacity to make appropriate clinical diagnoses and exercise reasoned medical judgments and to learn and kee abreast of medical developments; and
2. The ability to communicate those judgments and medical information to patients and other health care providers, with or withou the use of aids or devices, such as voice amplifiers; and
3. The physician capability to perform medical tasks such as physician examination and surgical procedures, with or without th use of aids or devices, such as corrective lenses or hearing aids.

"Medical condition" includes physiological, mental or psychological conditions or disorders, such as, but not limited to, orthopedic, visior speech, and hearing, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, emotional or ment illness, HIV disease, tuberculosis, drug addiction, and alcoholism.

"Chemical substances" is to be construed to include alcohol, drugs or medications, including those taken pursuant to a valid prescriptio for legitimate medical purposes and in accordance with the prescriber's direction.

"Currently" does not mean on the day of, or even in the weeks or months preceding the completion of this application. Rather it mean

ALL QUESTIONS ANSWERED 'YES' MUST BE EXPLAINED ON A SEPARATE ATTACHED SHEET OF PAPER

1. Do you have a medical condition which in any way impairs or limits your ability to practice medicine with reasonable skill and safety? ____Yes ____N

2. If you have a medical condition which in any way impairs or limits your ability to practice medicine is that impairment or limitation reduced or ameliorate because of the field of practice, the setting, or the manner in which you have chosen to practice? ____Yes ____No _✓_N/

3. If you use chemical substances, does your use of chemical substance(s) in any way impair or limit your ability to practice medicine with reasonable sk and safety? ____Yes ____No _✓_N/

4. Have you failed to initiate the performance of public service within one year after the date the public service is required to begin to satisfy a requireme of your receiving a loan or scholarship from the federal government or a state or local government for your medical education? ____Yes _✓_N

5. Have you been a defendant in a legal action involving professional liability (malpractice) or had a professional liability claim paid in your behalf or pa such a claim yourself? ____Yes _✓_N

6. Have you ever been investigated for, charged with, convicted of, or plead guilty or nolo contendere to, any offense or violation of any federal, state local law, including any foreign country, which is a misdemeanor, gross misdemeanor, or felony, excluding any minor traffic offense (Driving or in contr of a motor vehicle while under the influence of any substance is **not considered a minor traffic offense**) or which is related to the manufacture, distributio prescribing, or dispensing of controlled substances? ____Yes _✓_N

7. Have you ever been denied a license, permission to practice medicine or any other healing arts, or permission to take an examination to practice medici or any other healing arts in any state, country or U.S. territory? ____Yes _✓_N

8. Have you ever had a medical license revoked, suspended, limited, or restricted in any state, country or U.S. territory? ____Yes _✓_N

9. Have you ever voluntarily surrendered a license to practice a healing art in any state, country or U.S. territory? ____Yes _✓_N

10. Have you ever been denied membership or expelled from a medical society or other professional medical organization? ____Yes _✓_N

11. Have you ever been investigated for, charged with, or convicted of any violation of a statute, rule or regulation governing the practice of medicine l any medical licensing board, hospital, medical society, governmental entity or other agency? ____Yes _✓_N

12. Have you ever surrendered your state or federal controlled substance registration or had it revoked or restricted in any way? ____Yes _✓_N

13. List all hospitals where you have had staff privileges denied, suspended, limited, revoked or not renewed by the hospital. List any and all resignatio from any medical staff in lieu of disciplinary or administrative action. (Please Note: Do not include suspensions or restrictions for failure to complete hosp medical records, attend hospital department or staff meetings, or maintain required malpractice insurance).

Hospital	Mailing Address	Type of Action	Dates of Action From (Mo./Yr.) To (Mo./Yr.)

If more space is needed, attach separate sheet.

PLEASE CHECK ONE OF THE FOLLOWING:

_✓_ 1. I have earned a minimum of 40 hours approved AMA Category I continuing medical education (CME) for the biennial period July 1, 1995, throu June 30, 1997.

____ 2. I was initially licensed in Nevada during the second six months of the biennial period July 1, 1995, through June 30, 1997 and have earned minimum of 30 hours approved AMA Category I continuing medical education (CME).

____ 3. I was initially licensed in Nevada during the third six months of the biennial period July 1, 1995, through June 30, 1997 and have earnec minimum of 20 hours approved AMA Category I continuing medical education (CME).

____ 4. I was initially licensed in Nevada during the fourth six months of the biennial period July 1, 1995, through June 3, 1997 and have earnec minimum of 10 hours approved AMA Category I continuing medical education (CME).

____ 5. I am exempt from submitting proof of continuing medical education (CME) because I have completed a full year of residency or fellowship traini during the biennial period July 1, 1995, through June 30, 1997.

Signature________________
Signature stamp unacceptable

IMPORTANT: ATTACH COPIES OF PROOF OF DECLARED CME CREDITS. PROOF OF CME CREDITS WILL NOT BE RETURNE

I HAVE____ HAVE NOT _✓_ ACTIVELY PRACTICED IN NEVADA WITHIN THE PAST 12 MONTHS. (CHECK ONE)

I HEREBY CERTIFY THAT I AM THE PERSON NAMED IN THIS APPLICATION FOR REGISTRATION RENEWAL C LICENSE TO PRACTICE MEDICINE IN THE STATE OF NEVADA AND THAT ALL STATEMENTS I HAVE MADE HERE ARE TRUE.

310-360-8530 | 7/14/97 | ________
Business Telephone # | Date | Signature (SIGNATURE STAMP UNACCEPTABLE)

APPLICATION FOR REGISTRATION RENEWAL
NEVADA STATE BOARD OF MEDICAL EXAMINERS

Post Office Box 7238 Reno, Nevada 89510 Phone (702) 688-2559

Date Received by State Board: [illegible]

License No. ______

File No. ______

This shaded section for BOARD USE ONLY

[Her]eby apply for renewal of biennial registration and enclose the appropriate fees as indicated below:

√ ACTIVE STATUS $420
___ INACTIVE STATUS $150 (see attached NRS 630.255 & 630.257)
___ RETIRED STATUS $ 50 (see attached NRS 630.256 & 630.257) (MUST NOT BE PRACTICING MEDICINE IN ANY STATE)
___ P.A. SUPERVISING PHYSICIAN $200

PLEASE NOTE: NEVADA HAS NO GRACE PERIOD. LICENSES NOT RENEWED BY JULY 1, 1995 ARE AUTOMATICALLY SUSPENDED FOR NON-PAYMENT.

Stephen L.G. Rothman, MD
1701 W Charleston #100
Las Vegas NV 89102-0000

Make checks payable to: NEVADA STATE BOARD OF MEDICAL EXAMINERS (Foreign checks must indicate "U.S. FUNDS")

INSTRUCTIONS - TYPE OR PRINT LEGIBLY

1. YOUR CURRENT M.D. LICENSE EXPIRES ON **JUNE 30, 1995.** THIS IS THE NOTICE TO RENEW YOUR M.D. LICENSE.
2. To be eligible to act as a supervising physician for a physician assistant, complete the enclosed Application for Approval as Supervising Physician form.
3. ACTIVE STATUS REGISTRATION RENEWAL REQUIRES THE SUBMISSION OF PROOF OF 40 HOURS AMA CATEGORY I, CONTINUING MEDICAL EDUCATION completed during July 1, 1993 through June 30, 1995. Submit your proof of CME with your completed Application for Registration Renewal form.
4. In order to provide sufficient time for processing, please complete and return your Application for Registration Renewal form and Application for Approval as Supervising Physician form (if applicable) with your proof of 40 hours AMA Category I CME and the correct fee(s) **PRIOR TO JULY 1, 1995.** Use the enclosed self-addressed envelope to return your completed form(s) and fee(s).
5. If your name and/or address has changed from that printed on this form, clearly indicate that change in the space provided. A notarized or certified copy of the document authorizing your name change (marriage license, divorce decree, etc.) must be included.

Name ______

Street ______

City ______ County ______ State ______ Zip Code ______

6. IF YOU HAVE RETIRED OR MOVED YOUR PRACTICE, PLEASE INDICATE THE LOCATION OF FORMER PATIENT RECORDS BELOW:

Name ______

Street ______

City ______ County ______ State ______ Zip Code ______

YOUR LICENSE REGISTRATION WILL NOT BE RENEWED WITHOUT SUBMISSION OF THE CORRECT FEE(S), PROPERLY COMPLETED FORM(S) AND PROOF OF 40 HOURS OF CME.

<u>ALL</u> PAGES OF THE FORM(S) MUST BE COMPLETED AND RETURNED.

ALL FEES ARE NON-REFUNDABLE. DO NOT SEND CASH THROUGH THE MAIL.

PLEASE ALLOW 60 DAYS FOR THE PROCESSING OF YOUR REGISTRATION RENEWAL.

PLEA[illegible] PROVIDE ALL INFORMATION AS R[illegible]UESTED.

1. Are you currently active in medicine?
   a. ( ) YES, in training.
   b. ( ) YES, working full-time.
   c. (✓) YES, working part-time.
   d. ( ) NO, retired.
   e. ( ) NO, other (specify ______)

2. Please indicate your primary, secondary and tertiary specialties and percent of time spent in each, using the following codes.

SPECIALTY CODE:

1	ADOLESCENT MEDICINE	35	NEURORADIOLOGY	64	PED, UROLOGY
2	AEROSPACE MEDICINE	36	NUCLEAR MEDICINE	65	PEDIATRICS
3	ALLERGY / IMMUNOLOGY	37	NUTRITION	66	PHYSICAL MED / REHAB
4	ANESTHESIOLOGY	38	OBSTETRIC / GYNECOLOGY	96	PHYSICIAN ASSISTANT
5	BLOODBANKING	39	OBSTETRICS	67	PREVENTIVE MED
6	BRONCO-ESOPHAGOLOGY	40	OCCUPATIONAL MED	68	PSYCHIATRY
7	CARDIOVASC DISEASES	41	ONCOLOGY	69	PSYCHOANALYSIS
8	CATSCAN / ULTRASOUND	45	ONCOLOGY, GYNECOLOGIC	70	PSYCHOMATIC MEDICINE
9	CHILD NEUROLOGY	42	ONCOLOGY, HEMATOLOGY	71	PUBLIC HEALTH
10	CHILD PSYCHIATRY	43	ONCOLOGY, RADIATION	72	PULMONARY DISEASES
11	CLINICAL PHARMACOL	44	ONCOLOGY, SURGICAL	73	RADIOLOGY
12	CRITICAL CARE	46	OPHTHALMOLOGY	74	RADIOLOGY, DIAGNOSTIC
13	DERMATOLOGY	47	OTOLARYNGOLOGY	75	RADIOLOGY, NUCLEAR
14	EMERGENCY MEDICINE	48	OTOLOGY	76	RADIOLOGY, THERAPEUT
15	ENDOCRINOLOGY	49	PAIN MANAGEMENT	77	RHEUMATOLOGY
16	FAMILY PRACTICE	50	PATHOLOGY	78	RHINOLOGY
17	GASTROENTEROLOGY	51	PATHOLOGY, ANATOMIC	79	SLEEP DISORDERS
18	GENERAL PRACTICE	52	PATHOLOGY, CLINICAL	100	SPORTS MEDICINE
19	GERIATRICS	53	PATHOLOGY, FORENSIC	80	SURGERY, ABDOMINAL
20	GYNECOLOGY	54	PED, ALLERGY	81	SURGERY, CARDIOVASC
21	HEMATOLOGY	55	PED, CARDIOLOGY	91	SURGERY, COLON/RECTAL
22	HYPNOSIS	99	PED, CRITICAL CARE	82	SURGERY, GENERAL
23	IMMUNOLOGY	97	PED, EMERGENCY MED	83	SURGERY, HAND
24	INFECTIOUS DISEASES	56	PED, ENDOCRINOLOGY	84	SURGERY, HEAD/NECK
25	INFERTILITY	57	PED, HEMAT / ONCOLOGY	92	SURGERY, MAXILLOFAC
26	INTERNAL MEDICINE	58	PED, INFECTIOUS DIS	93	SURGERY, NEUROLOGICAL
27	LARYNGOLOGY	59	PED, INTENSIVIST	85	SURGERY, ORTHOPEDIC
28	LEGAL MEDICINE	60	PED, NEPHROLOGY	86	SURGERY, PLASTIC
29	MATERNAL / FETAL MED	98	PED, NEUROLOGY	87	SURGERY, THORACIC
30	NEO / PERINATAL MED	101	PED, OPHTHALMOLOGY	88	SURGERY, TRAUMATIC
31	NEOPLASTIC DISEASES	61	PED, PHYSIATRY	89	SURGERY, UROLOGIC
32	NEPHROLOGY	95	PED, PULMONARY	90	SURGERY, VASCULAR
33	NEUROLOGY	62	PED, RADIOLOGY	94	UROLOGY
34	NEUROPATHOLOGY	63	PED, SURGERY		

	Code	Percent of Time	Board Certified (Indicate Yes/No)
Primary	73		YES
Secondary	74		YES
Tertiary			

PLEASE INDICATE AMERICAN BOARD OF MEDICAL SPECIALTIES BOARD CERTIFICATION:

		Date of Initial Certification (Mo./Yr.)	Date of Last Recertification (Mo./Yr.)
Board	RADIOLOGY	1974	—
Subboard			

3. How many hours per week do you spend in each of the following activities?

1-2 hours Patient care or services
____ hours Administration (schools, agencies, associations, etc.)
____ hours Teaching medical courses
____ hours Research
____ hours Other (specify ______)

4. Form of employment is 1002. (Use the following codes.)

SELF-EMPLOYED
1001 Solo Practice
1002 Partnership or Group Practitioners

SALARIED, EMPLOYED BY
1003 Individual Practitioner
1004 Partnership or Group of Practitioners
1005 Group Health Plan Facility (such as H.M.O.)
1006 Other Non-Government Employer (hospital, school, etc
1007 Federal Government (armed services personnel only)
1008 Federal Government (civilian, P.H.S., etc.)
1009 State Government
1010 County Government
1011 Local Government
1012 Other (specify ______)

All of the following questions ref[illegible]o the time period of July 1, 1993 t[illegible]ugh the present date only.
FOR ALL YES RESPONSES, PLEASE EXPLAIN ON A SEPARATE SHEET AND RETURN WITH THIS REGISTRATION APPLICATION.

For the purpose of the following questions, these phrases or words have these meanings:

"[illegible]bility to practice medicine" is to be construed to include all of the following:

1. The cognitive capacity to make appropriate clinical diagnoses and exercise reasoned medical judgments and to learn and keep abreast of medical developments; and
2. The ability to communicate those judgments and medical information to patients and other health care providers, with or without the use of aids or devices, such as voice amplifiers; and
3. The physician capability to perform medical tasks such as physician examination and surgical procedures, with or without the use of aids or devices, such as corrective lenses or hearing aids.

"Medical condition" includes physiological, mental or psychological conditions or disorder, such as, but not limited to, orthopedic, visual, speech, and hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, mental retardation, emotional or mental illness, specific learning disabilities, HIV disease, tuberculosis, drug addiction, and alcoholism.

"Chemical substances" is to be construed to include alcohol, drugs or medications, including those taken pursuant to a valid prescription for legitimate medical purposes and in accordance with the prescriber's direction, as well as those used illegally.

"Currently" does not mean on the day of, or even in the weeks or months preceding the completion of this application. Rather, it means recently enough so that the use of drugs may have an ongoing impact on one's functioning as a licensee, or within the past two years.

"Illegal use of controlled dangerous substances" means the use of controlled dangerous substances obtained illegally (e.g. heroin or cocaine) as well as the use of controlled dangerous substances which are not obtained pursuant to a valid prescription or not taken in accordance with the directions of a licensed health care practitioner.

1. Have you failed to repay, in accordance with the terms of the loan, any direct loan or loan which is insured or guaranteed by the Federal Government or a state or local government which you received to finance all or any part of your medical education? ☐ Yes ☑ No
2. Do you have a medical condition which in any way impairs or limits your ability to practice medicine with reasonable skill and safety? ☐ Yes ☑ No
3. Does your use of chemical substance(s) in any way impair or limit your ability to practice medicine with reasonable skill and safety? ☐ Yes ☑ No
4. Are the limitations or impairments caused by your medical condition reduced or ameliorated because of the field of practice, the setting, or the manner in which you have chosen to practice? ☐ Yes ☑ No
5. Have you been diagnosed as having, or have you been treated for pedophilia, exhibitionism, or voyeurism? ☐ Yes ☑ No
6. Are you currently engaged in the illegal use of controlled dangerous substances? ☐ Yes ☑ No
7. Have you been a defendant in a legal action involving professional liability (malpractice) or had a professional liability claim paid in your behalf or paid such a claim yourself? ☐ Yes ☑ No
8. Have you been investigated for, charged with or convicted of, or pled nolo contendere to a violation of any federal, state or local law relating to the manufacture, distribution, prescribing, or dispensing of controlled substances? ☐ Yes ☑ No
9. Have you been arrested, investigated for, charged with or convicted of, or pled nolo contendere to any offense, misdemeanor or felony in any state, the United States, or a foreign country? ☐ Yes ☑ No
10. Have you previously applied for medical licensure in Nevada (including a residency program)? ☐ Yes ☑ No
11. Have you failed to initiate the performance of public service within one year after the date the public service is required to begin to satisfy a requirement of your receiving a loan or scholarship from the federal government or a state or local government for your medical education? ☐ Yes ☑ No
12. Have you been denied a license, permission to practice medicine or any other healing arts, or permission to take an examination to practice medicine or any other healing arts in any state, country or U.S. territory? ☐ Yes ☑ No
13. Have you had a medical license revoked, suspended, limited, or restricted in any state, country or U.S. territory? ☐ Yes ☑ No
14. Have you voluntarily surrendered a license to practice in the healing arts in any state, country or U.S. territory? ☐ Yes ☑ No
15. Have you been denied membership or expelled from a medical society or other professional medical organization? ☐ Yes ☑ No
16. List all hospitals where you have had staff privileges denied, suspended, limited, revoked or not renewed by the hospital. List any and all resignations from any medical staff in lieu of disciplinary or administrative action. (Please Note: Do not include suspensions or restrictions for failure to complete hospital medical records, attend hospital department or staff meetings, or maintain required malpractice insurance.)

Hospital	Mailing Address	Type of Action	Dates of Action From (Mo./Yr.)	To (Mo./Yr.)
None				

17. Have you been investigated for, charged with, or convicted of any violation of a statute, rule or regulation governing the practice of medicine by any medical licensing board, hospital, medical society, governmental entity or other agency? ☐ Yes ☑ No
18. Have you surrendered your state or federal controlled substance registration or had it revoked or restricted in any way? ☐ Yes ☑ No

CONTINUING MEDICAL EDUCATION

630.153 Continuing education: General requirements; exemption; failure to comply.

1. Except as otherwise provided in subsection 2 and NAC 630.157, each holder of a license to practice medicine shall, at the time of the biennial registration, submit to the board by the final date set by the board for submitting applications for biennial registration evidence, in such form as the board requires, [illegible]he has completed 40 full hours of continuing medical education during the preceding 2 years in one or more educational programs. Each educational [illegible]ram must:

(a) Offer, upon successful completion of the program, a certificate of Category 1 credit as recognized by the American Medical Association to the holder of the license;

(b) Be approved by the board; and

(c) Be sponsored in whole or in part by an organization accredited or deemed to be an equivalent organization to offer such programs by the American Medical Association or the Liaison Committee on Continuing Medical Education.

2. Any holder of a license who has completed a full year of residency or fellowship any time during the period for biennial registration immediately

preceding the submission of the application [illegible]iennial registration is exempt from the requirements [illegible] forth in subsection 1.

3. If the holder of a license fails to submit [illegible]dence of his completion of continuing medical educat[illegible] within the time and in the manner prescribed by subsection 1, his license will not be renewed. Such a person may not resume the practice of medicine unless, within 2 years after the end of the biennial period of registration, he:

(a) Pays a fee to the board which is twice the fee for biennial registration otherwise prescribed by subsection 1 of NRS 630.290;

(b) Submits to the board, in such form as it requires, evidence that he has completed 40 full hours of continuing medical education in addition to that otherwise required by subsection 1 or NAC 630.157; and

(c) Is found by the board to be otherwise qualified for active status pursuant to the provisions of this chapter and chapter 630 of NRS.

(Added to NAC by Bd. of Medical Exam'rs, 7-31-85, eff. 8-1-85; A 6-23-86; 11-21-88; 9-12-91)

PLEASE CHECK ONE OF THE FOLLOWING:

✓ 1. I have earned a minimum of 40 hours approved AMA Category I continuing medical education (CME) for the biennial period July 1, 1993 through June 30, 1995.

___ 2. I was initially licensed in Nevada during the second six months of the biennial period July 1, 1993, through June 30, 1995 and have earned a minimum of 30 hours approved AMA Category I continuing medical education (CME).

___ 3. I was initially licensed in Nevada during the third six months of the biennial period July 1, 1993, through June 30, 1995 and have earned a minimum of 20 hours approved AMA Category I continuing medical education (CME).

___ 4. I was initially licensed in Nevada during the fourth six months of the biennial period July 1, 1993, through June 30, 1995 and have earned a minimum of 10 hours approved AMA Category I continuing medical education (CME).

___ 5. I am exempt from submitting proof of continuing medical education (CME) because I have completed a full year of residency or fellowship training during the biennial period July 1, 1993 through June 30, 1995.

Signature ______________________________
(SIGNATURE STAMP UNACCEPTABLE)

IMPORTANT: ATTACH COPIES OF PROOF OF DECLARED CME CREDITS.
PROOF OF CME CREDITS WILL NOT BE RETURNED.

I hereby certify that I am the person named in this Application for Registration Renewal of license to practice medicine in the State of Nevada; that all statements I have made herein are true; that I am the original and lawful possessor of and person named in the various documents and credentials furnished to the Board in connection with this renewal application.

I HAVE ☑ HAVE NOT ☐ ACTIVELY PRACTICED IN NEVADA WITHIN THE PAST 12 MONTHS. (CHECK ONE)

If you have not practiced medicine in the State of Nevada during the period July 1, 1994, through June 30, 1995, please contact the Board office for further instruction.

Business Telephone #	Date	X Signature (SIGNATURE STAMP UNACCEPTABLE)

630.288 Biennial registration: Fee; failure to pay fee; revocation and restoration of license; notice to licensee.

1. Each holder of a license to practice medicine must pay to the secretary-treasurer of the board on or before July 1 of each alternate year the applicable fee for biennial registration. This fee must be collected for the period for which a physician is licensed.

2. When a holder of a license fails to pay the fee for biennial registration after it becomes due, his license to practice medicine in this state is automatically suspended. The holder may, within 2 years after the date his license is suspended, upon payment of twice the amount of the current fee for biennial registration to the secretary-treasurer, and after he is found to be in good standing and qualified under the provisions of this chapter, be reinstated to practice.

3. The board shall notify a licensee:

(a) At least once that his fee for biennial registration is due; and

(b) That his license is suspended for nonpayment of the fee. A copy of this notice must be sent to the Drug Enforcement Administration o[illegible] United States Department of Justice or its successor agency.

(Added to NRS by 1985, 2223; A 1987, 196)

630.255 Inactive licensees: Leaving state; ceasing or failing to practice; reinstatement.

1. Any licensee who changes the location of his practice of medicine from this state to another state or country, has never engaged in the practice of medicine in this state after licensure or has ceased to engage in the practice of medicine in this state for 12 consecutive months must be placed on inactive status.

2. Before resuming the practice of medicine in this state, the inactive registrant shall:

(a) Notify the board of his intent to resume the practice of medicine in this state;

(b) File an affidavit with the board describing his activities during the period of his inactive status;

(c) Complete the form for registration for active status;

(d) Pay the applicable fee for biennial registration; and

(e) Satisfy the board of his competence to practice medicine.

3. If the board determines that the conduct or competence of the registrant during the period of inactive status would have warranted denial of an application for a license to practice medicine in this state, the board may refuse to place the registrant on active status.

(Added to NRS by 1985, 2222; A 1987, 195; 1993, 2299)

630.256 Retired licensees: Duties; requirements for reinstatement.

1. If a licensee retires from the practice of medicine, he shall notify the board in writing of his intention to retire, and the board shall record the fact of retirement. A licensee who is retired may not engage in the practice of medicine. Any licensee who is retired and desires to return to the practice of medicine, must, before resuming the practice of medicine in this state:

(a) Notify the board of his intent to resume the practice of medicine in this state;

(b) File an affidavit with the board describing his activities during the period of his retired status;

(c) Complete the form for registration for active status;

(d) Pay the applicable fee for biennial registration; and

(e) Satisfy the board of his competence to practice medicine.

2. If the board determines that the conduct or competence of the registrant during the period of retirement would have warranted denial of an application for a license to practice medicine in this state, the board may refuse to place the registrant on active status.

(Added to NRS by 1985, 2222; A 1987, 195)

630.257 Re-examination of inactive or retired licensee. If a licensee does not practice allopathic medicine for a period of more than 12 consecutive months, the board may require him to take the same examination to test medical competency as that given to applicants for a license.

(Added to NRS by 1985, 2222; A 1993, 2300)

APPLICATION FOR REGISTRATION

NEVADA STATE BOARD OF MEDICAL EXAMINERS

Post Office Box 7238 Reno, Nevada 89510 Phone (702) 688-2559

Date Received by State Board: MAY 11 1993

License No. ______

File No. ______

New ☐ Renewal ☐

This shaded section for BOARD USE ONLY

I hereby apply for certificate of biennial registration and enclose the appropriate fee as indicated below:

- ☑ ACTIVE STATUS $320.00 ✓
- ☐ INACTIVE STATUS $150.00
- ☐ RETIRED STATUS $ 50.00

NOTE: NO GRACE PERIOD – LICENSED NOT RENEWED BY JULY 1 ARE AUTOMATICALLY SUSPENDED FOR NON PAYMENT.

Stephen L.G. Rothman, MD
17●1 W Charleston ●1●●
Las Vegas NV 891●2-●●●●

Make checks payable to:
BOARD OF MEDICAL EXAMINERS
(Foreign checks must indicate "U.S. FUNDS")

INSTRUCTIONS – TYPE OR PRINT LEGIBLY

1. YOUR CURRENT LICENSE EXPIRES ON **JUNE 30, 1993.** This is the notice to renew your M.D. license. You may apply for your license renewal upon receipt of this notice.

2. IN ORDER TO PROVIDE SUFFICIENT TIME FOR PROCESSING, PLEASE RETURN THIS RENEWAL APPLICATION WITH THE CORRECT RENEWAL FEE PRIOR TO **JULY 1, 1993.**

3. Use the enclosed self-addressed envelope to return this renewal notice and registration fee. ACTIVE registration requires submission of proof of 40 hours AMA Category I CME. If you register your license INACTIVE or RETIRED, you may not practice medicine in Nevada, including the writing of prescriptions.

4. All fees are non-refundable. Do not send cash through the mail.

5. If your name and/or address has changed from that printed on this notice, clearly indicate that change in the space provided. A NOTARIZED or CERTIFIED copy of the document authorizing your name change (marriage license, divorce decree, etc.) must be included.

Name ______

Street ______

City ______ County ______ State ______ Zip Code ______

A LICENSE WILL NOT BE RENEWED WITHOUT THE CORRECT FEE AND SUBMISSION OF THIS PROPERLY COMPLETED FORM.

ACTIVE REGISTRANTS MUST SUBMIT PROOF OF 40 HOURS AMA CATEGORY I CONTINUING MEDICAL EDUCATION (CME).

PLEASE ALLOW 60 DAYS FOR THE PROCESSING OF YOUR LICENSE RENEWAL. ALL PAGES MUST BE COMPLETED AND RETURNED.

ANSWER THE FOLLOWING QUESTIONS AND RETURN IN THE ENCLOSED SELF-ADDRESSED ENVELOPE.

1. Are you currently active in medicine?
   - a. ( ) YES, in training.
   - b. (✓) YES, working full-time.
   - c. ( ) YES, working part-time.
   - d. ( ) NO, retired.
   - e. ( ) NO, other (specify ______)

2. Please indicate your primary, secondary and tertiary specialties and percent of time spent in each, using the following codes:

SPECIALTY CODE:

1 ADOLESCENT MEDICINE
2 AEROSPACE MEDICINE
3 ALLERGY/IMMUNOLOGY
4 ANESTHESIOLOGY
5 BLOODBANKING
6 BRONCO-ESOPHAGOLOGY
7 CARDIOVASC DISEASES
8 CATSCAN/ULTRASOUND
9 CHILD NEUROLOGY
10 CHILD PSYCHIATRY
11 CLINICAL PHARMACOL
12 CRITICAL CARE
13 DERMATOLOGY
14 EMERGENCY MEDICINE
15 ENDOCRINOLOGY
16 FAMILY PRACTICE
17 GASTROENTEROLOGY
18 GENERAL PRACTICE
19 GERIATRICS
20 GYNECOLOGY
21 HEMATOLOGY
22 HYPNOSIS
23 IMMUNOLOGY
24 INFECTIOUS DISEASES
25 INFERTILITY
26 INTERNAL MEDICINE
27 LARYNGOLOGY
28 LEGAL MEDICINE
29 MATERNAL/FETAL MED
30 NEO/PERINATAL MED
31 NEOPLASTIC DISEASES
32 NEPHROLOGY
33 NEUROLOGY
34 NEUROPATHOLOGY
35 NEURORADIOLOGY
36 NUCLEAR MEDICINE
37 NUTRITION
38 OBSTETRIC/GYNECOLOGY
39 OBSTETRICS
40 OCCUPATIONAL MED
41 ONCOLOGY
42 ONCOLOGY, GYNECOLOGIC
43 ONCOLOGY, HEMATOLOGY
44 ONCOLOGY, RADIATION
45 ONCOLOGY, SURGICAL
46 OPHTHALMOLOGY
47 OTOLARYNGOLOGY
48 OTOLOGY
49 PAIN MANAGEMENT
50 PATHOLOGY
51 PATHOLOGY, ANATOMIC
52 PATHOLOGY, CLINICAL
53 PATHOLOGY, FORENSIC
54 PED, ALLERGY
55 PED, CARDIOLOGY
56 PED, ENDOCRINOLOGY
57 PED, HEMAT/ONCOLOGY
58 PED, INFECTIOUS DIS
59 PED, INTENSIVIST
60 PED, NEPHROLOGY
61 PED, PHYSIATRY
62 PED, RADIOLOGY
63 PED, SURGERY
64 PED, UROLOGY
65 PEDIATRICS
66 PHYSICAL MED/REHAB
67 PREVENTATIVE MED
68 PSYCHIATRY
69 PSYCHOANALYSIS
70 PSYCHOMATIC MEDICINE
71 PUBLIC HEALTH
72 PULMONARY DISEASES
73 RADIOLOGY
74 RADIOLOGY, DIAGNOSTIC
75 RADIOLOGY, NUCLEAR
76 RADIOLOGY, THERAPEUT
77 RHEUMATOLOGY
78 RHINOLOGY
79 SLEEP DISORDERS
80 SURGERY, ABDOMINAL
81 SURGERY, CARDIOVASC
82 SURGERY, COLON/RECTAL
83 SURGERY, GENERAL
84 SURGERY, HAND
85 SURGERY, HEAD/NECK
86 SURGERY, MAXILLOFAC
87 SURGERY, NEUROLOGICAL
88 SURGERY, ORTHOPEDIC
89 SURGERY, PLASTIC
90 SURGERY, THORACIC
91 SURGERY, TRAUMATIC
92 SURGERY, UROLOGIC
93 SURGERY, VASCULAR
94 UROLOGY

	Code	Percent of Time	Board Certified (Indicate Yes/No)
Primary	74	100%	Y
Secondary			
Tertiary			

PLEASE INDICATE AMERICAN BOARD OF MEDICAL SPECIALTIES BOARD CERTIFICATION:

Board Radiology

Subboard ______

3. How many hours per week do you spend in each of the following activities?

40 hours Patient care or services
______ hours Administration (schools, agencies, association, etc.)
1-2 hours Teaching medical courses
1-2 hours Research
8 hours Other (specify medicolegal Rev..)

4. Form of employment is 1002. (Use the following codes.)

SELF-EMPLOYED
1001 Solo Practice
1002 Partnership or Group Practitioners (circled)
SALARIED, EMPLOYED BY
1003 Individual Practitioner
1004 Partnership or Group of Practitioners
1005 Group Health Plan Facility (such as H.M.O.)
1006 Other Non-Government Employer (hospital, school, etc.)
1007 Federal Government (armed services personnel only)
1008 Federal Government (civilian P.H.S., etc.)
1009 State Government
1010 County Government
1011 Local Government
1012 Other (specify ______)

All of the following questions refer to the time period of **July 1, 1991, through the present date** only. FOR ALL **YES** RESPONSES, PLEASE EXPLAIN ON A SEPARATE SHEET AND RETURN WITH THE RENEWAL APPLICATION.

5. Have you been rejected for membership by any medical society? Yes ❑ No ☑
6. Have you been denied a license to practice medicine? Yes ❑ No ☑
7. Have you been denied staff membership with any licensed hospital, nursing home or other hospital care facility with an organized medical staff? Yes ❑ No ☑
8. Have you been censured, reprimanded, disciplined, had privileges limited, had privileges suspended, been put on probation, or been requested to withdraw from any licensed hospital, nursing home, clinic, or other hospital care facility with an organized medical staff, in which you trained, have been a staff member, have been a partner, or have held hospital privileges? Yes ❑ No ☑
9. Have you lost American Board certification because of disciplinary action? Yes ❑ No ☑
10. Have any U.S. state and/or Canadian provincial licensing or disciplinary agencies limited, restricted, suspended or revoked a license you have held or taken any other disciplinary action against you? Yes ❑ No ☑
11. Have you voluntarily surrendered a license issued to you by any state and/or Canadian provincial licensing agency while an investigation or other disciplinary action was pending? Yes ❑ No ☑
12. Have you been notified of any current/pending charges or complaints filed against you with any state and/or Canadian provincial licensing or disciplinary agency? Yes ❑ No ☑
13. Have you been diagnosed or treated for any physical illness that would serve to hinder your ability to practice medicine? Yes ❑ No ☑
14. Have you been diagnosed or treated for mental illness? Yes ❑ No ☑
15. Have you been chemically dependent? Yes ❑ No ☑
16. Have you interrupted your training because of illness or impairment? Yes ❑ No ☑
17. Have you been unable to practice medicine because of illness or impairment? Yes ❑ No ☑
18. Have you been denied a controlled substances registration certificate by the Drug Enforcement Administration (DEA) or State Board of Pharmacy or other lawful authority concerned with controlled substances or been censured, reprimanded, restricted, voluntarily surrendered, placed on probation or had such authority revoked? Yes ❑ No ☑
19. Have you been indicted, arrested, charged with, convicted, pled guilty or nolo contendere in any criminal prosecution under the laws of any state or of the United States, for any offense reasonably related to the qualifications, functions or duties of a physician, for any offense an essential element of which is fraud, dishonesty or an act of violence, or for any offense involving moral turpitude? Yes ❑ No ☑
20. Have you been a defendant in a legal action involving professional liability (malpractice) or had a professional liability claim paid in your behalf or paid such a claim yourself? Yes ❑ No ☑
21. Have you been denied provider participation in any State Medicaid or Federal Medicare Program? Yes ❑ No ☑
22. Have you been terminated from, sanctioned or penalized by, or had to repay monies to any State Medicaid or Federal Medicare Program as a result of administrative or criminal action? Yes ❑ No ☑

PLEASE LIST CURRENT HOSPITAL AFFILIATION(S):

Name ____________ Address ____________

Name ____________ Address ____________

Name ____________ Address ____________

Name ____________ Address ____________

CONTINUING MEDICAL EDUCATION

630.153 Continuing education: General requirements; exemption; failure to comply.

1. Except as otherwise provided in subsection 2 and NAC 630.157, each holder of a license to practice medicine shall, at the time of the biennial registration, submit to the board by the final date set by the board for submitting applications for biennial registration evidence, in such form as the board requires, that he has completed 40 full hours of continuing medical education during the preceding 2 years in one or more educational programs. Each educational program must:

(a) Offer, upon successful completion of the program, a certificate of Category 1 credit as recognized by the American Medical Association to the holder of the license;

(b) Be approved by the board; and

(c) Be sponsored in whole or in part by an organization accredited or deemed to be an equivalent organization to offer such ograms by the American Medical Association or the Liaison Committee on Continuing Medical Education.

2. Any holder of a license who has completed a full year of residency or fellowship any time during the period for biennial registration immediately preceding the submission of the application for biennial registration is exempt from the requirements set forth in subsection 1.

3. If the holder of a license fails to submit evidence of his completion of continuing medical education within the time and in the manner prescribed by subsection 1, his license will not be renewed. Such a person may not resume the practice of medicine unless, within 2 years after the end of the biennial period of registration, he:

(a) Pays a fee to the board which is twice the fee for biennial registration otherwise prescribed by subsection 1 of NRS 630.290;

(b) Submits to the board, in such form as it requires, evidence that he has completed 40 full hours of continuing medical education in addition to that otherwise required by subsection 1 or NAC 630.157; and

(c) Is found by the board to be otherwise qualified for active status pursuant to the provisions of this chapter and chapter 630 of NRS.

(Added to NAC by Bd. of Medical Exam'rs, 7-31-85, eff. 8-1-85; A 6-23-86; 11-21-88; 9-12-91)

PLEASE CHECK ONE OF THE FOLLOWING:

_____ 1. I have earned a minimum of 40 hours approved AMA Category I continuing medical education (CME) for the period July 1, 1991, through June 30, 1993.

_____ 2. I am exempt because I have completed a full year of residency or fellowship training during the period for biennial registration immediately preceding the submission of this application.

_____ 3. I am exempt as I am applying for INACTIVE or RETIRED status.

Signature ______________________________
(SIGNATURE STAMP UNACCEPTABLE)

IMPORTANT: ATTACH COPIES OF CERTIFICATES OF DECLARED CME CREDITS
PROOF OF CME CREDITS WILL NOT BE RETURNED.

Date of Birth: 1/ /42 (month/day/year)

Social Security Number: ______________

DEA Number: ______________

Medical School: Albert Einstein College of Medicine - Bronx (City) NY (State)

Internship: Mt. Sinai Medical Center, New York (City) NY (State)

Residency: ______________ City ______ State ______

______________ City ______ State ______

______________ City ______ State ______

Fellowship: Yale University School of Medicine - New Haven, (City) CT (State)

I hereby certify that I am the person named in this application for renewal of license to practice medicine in the state of Nevada; that all statements I have made herein are true; that I am the original and lawful possessor of and person named in the various documents and credentials furnished to the Board in connection with this renewal application.

I HAVE ☐ HAVE NOT ☐ ACTIVELY PRACTICED IN NEVADA WITHIN THE PAST 12 MONTHS. (CHECK ONE)

______________ Business Telephone #

4/30/93 Date

X ______________ Signature (SIGNATURE STAMP UNACCEPTABLE)

ALL PAGES MUST BE RETURNED OR YOUR LICENSE WILL NOT BE RENEWED.

APPLICATION FOR REGISTRATION

NEVADA STATE BOARD OF MEDICAL EXAMINERS

Post Office Box 7238 Reno, Nevada 89510 Phone (702) 329-2559

I hereby apply for certificate of biennial registration and enclose the appropriate fee as indicated below:

- ☑ ACTIVE STATUS $400.00
- ☐ INACTIVE STATUS $150.00
- ☐ RETIRED STATUS $ 50.00

NOTE: NO GRACE PERIOD — LICENSES NOT RENEWED BY JULY 1 ARE AUTOMATICALLY SUSPENDED FOR NON PAYMENT

NRS630 explanation of status on reverse side

Make checks payable to: BOARD OF MEDICAL EXAMINERS (Foreign Checks must indicate "U.S. Funds")

TYPE OR PRINT LEGIBLY

NAME ROTHMAN STEPHEN L. GABRIEL
Last First Middle

Social Security #

Business Phone (213) 326-8744

BUSINESS OR MAILING ADDRESS 3400 W. Lomita BLVD Torrance CA 90505
Street Address or P.O. Box Suite No. City State Zip Code

If you have retired or moved your practice, please indicate the location of former patient's records for the last 5 years below:

NAME

ADDRESS

PHONE # ( )

BOARD OF CERTIFICATION

Yes ✓ No

AM. Bd. of RADIOLOGY

Date of Certification or Recertification 1973

Primary Specialty (List only one) RADIOLOGY Sub-Specialties: NEURORADIOLOGY

I certify that within the past 24 months, I have completed a minimum of 40 hours of Continuing Medical Education, AMA-Category 1 and that I have in my files documentation of such. I understand that the CME requirement is mandated by NRS 630.253 and NAC 630.153.

Signature: Date

(No rubber stamps)

SINCE YOUR LAST REGISTRATION: (If any question is answered "yes," attach a detailed explanation.)

1. Have you been investigated by, or charged or convicted of unprofessional conduct, professional incompetence or gross or repeated malpractice by any medical licensing board or other agency, hospital or medical society? Yes ☐ No ☑
2. Have you been arrested, fined (over $100), charged with or convicted of a crime, indicted, imprisoned or placed on probation? Yes ☐ No ☑
3. Have you been investigated, arrested, charged or convicted for the possession, use of, or illegal sale or dispensing of controlled substances? Yes ☐ No ☑
4. Have you been denied a medical license or surrendered your license to practice in another jurisdiction or had your medical license or right to practice medicine revoked, suspended or limited in another jurisdiction. Yes ☐ No ☑
5. Have you had staff privileges in a hospital denied, suspended, limited, revoked or not renewed, or have you resigned from a medical staff in lieu of disciplinary or administrative action, excluding failure to complete medical records? Yes ☐ No ☑
6. Have any malpractice settlements, awards or judgments been made against you in any jurisdiction? Yes ☐ No ☑

STAFF PRIVILEGES: List all Nevada Hospitals in which you have any staff privileges: (Name and Location)

1.
2.
3.
4.
5.
6.

I certify that all my statements in this application are true. I have ☐ have not ☐ actively practiced in Nevada within the past 12 months. (Check one)

Signature: Date 9/20/91

(No rubber stamps)

NOTE: Have you signed both "signature" lines.

630.255 Inactive licensees: Leaving state; ceasing or failing to practice; reinstatement.

1. Any licensee who changes the location of his practice of medicine from this state to another state or country, has never engaged in the practice of medicine in this state after licensure or has ceased to engage in the practice of medicine in this state for a period of 12 consecutive months must be placed on inactive status upon notification of the board.

2. Before resuming the practice of medicine in this state, the inactive registrant shall:

(a) Notify the board of his intent to resume the practice of medicine in this state;

(b) File an affidavit with the board describing his activities during the period of his inactive status;

(c) Complete the form for registration for active status; and

(d) Pay the applicable fee for biennial registration.

3. If the board determines that the conduct of the registrant during the period of inactive status would have warranted denial of an application for a license to practice medicine in this state, the board may refuse to place the registrant on active status.

(Added to NRS by 1985, 2222)

630.256 Retired licensees: Duties; reinstatement. If a licensee retires from the practice of medicine, he shall notify the board in writing of his intention to retire, and the board shall record the fact of retirement. A licensee who is retired may not engage in the practice of medicine. If a licensee who is retired desires to return to the practice of medicine, he shall apply to the board for registration and pay the applicable fee for biennial registration.

(Added to NRS by 1985, 2222)

630.257 Re-examination of inactive or retired licensee. If a licensee does not practice allopathic or homeopathic medicine for a period of more than 12 consecutive months, the board may require him to take the same examination to test medical competency as that given to applicants for a license.

(Added to NRS by 1985, 2222)

REMINDER: NEVADA LAW REQUIRES NOTICE TO THE BOARD PRIOR TO CHANGING YOUR PRACTICE LOCATION OR CLOSURE OF OFFICE.
(NRS 630.254)

RECEIVED
JUL 05 1991 650pe
NEVADA STATE BOARD OF MEDICAL EXAMINERS
450 reg
250 app

STATE OF NEVADA
BOARD OF MEDICAL EXAMINERS
APPLICATION FOR LICENSURE

1. Name ROTHMAN, STEPHEN L. GABRIEL —
Last First Middle Maiden

If you have ever used another name, please indicate No

2. Business and/or Mailing Address 3400 Lomita Blvd., # 104 - Torrance, CA 90505
Street # City State Zip

3. Home Address
Street # City State Zip

4. Telephone Number (213) 326-8744 ( )
Office Home

5. Date of Birth 01/ 42 Place of Birth , NY

6. Citizenship: US Citizen X Alien Registration # Other
Submit a certified copy of birth certificate, Certificate of Naturalization and/or Alien Registration Card with this application.

7. Have you ever previously applied for medical licensure in Nevada? ☐ Yes ☒ No

If YES, give date of previous application N/A

8. List name and address of all colleges or universities attended other than schools where professional medical instruction was received. Have each school submit an official transcript directly to the board.

Name	Address	Dates of Attendance	
		From (Mo/Yr)	To (Mo/Yr)
Yeshiva University	500 W. 185 Str., NY, NY	9/59	6/63

9. List name and address of all schools where professional medical instruction was received. Have each school submit an official transcript directly to the board.

Name	Address	Place Where Instruction Received	Dates of Attendance	
			From (Mo/Yr)	To (Mo/Yr)
Albert Einstein College of Medicine	1300 Morris Park Ave.	Same	9/63	6/67

10. Doctor of Medicine Degree granted by:

Name of Medical School	Address of Medical School	Exact Date of Issuance
Albert Einstein College of Medicine	1300 Morris Park Ave.	6/2/67

11. Have you taken any part of the National Boards? ☒ Yes ☐ No If YES, list location, parts taken, date and score(s). Have certificate of scores submitted from National Boards to the board.

Location	Part Taken	Date	Result (Score(s))
New York, NY	All	7/1/68	?

FEB 22 1991

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JUL 05 1991
BOARD OF MEDICAL EXAMINERS

Have you taken SPEX or any part of the FLEX? ☒ Yes ☐ No If YES, list location, parts taken, date and score(s). Have certificate of scores submitted from FLEX/SPEX directly to the board.

Location	Part Taken	Date	Result (Score(s))
San Bernardino	–	12/6/90	82

13. Have you taken any part of ECFMG or FMGEMS? ☐ Yes ☒ No If YES, list part(s) taken, location, date and result(s) of examination Have certification of examination(s) submitted from the ECFMG directly to the board. List ECFMG # ________

Location	Part Taken	Date	Result (Score(s))
N/A			

14. Have you received ACGME* approved postgraduate training in the United States or Canada? ☐ Yes ☒ No If YES, fill in the information requested below.
*Accreditation Council on Graduate Medical Education

Hospital/ Institution	Mailing Address	Type of Service or Specialty	Dates of Attendance	
			From (Mo/Yr)	To (Mo/Yr)
Mt. Sinai Hospital	New York, NY	Medicine	1967	1968

15. Have you completed any ACGME*approved Fellowship programs? ☐ Yes ☒ No If YES, fill in the information requested below.

Institution	Mailing Address	Type of Fellowship	Dates of Attendance	
			From (Mo/Yr)	To (Mo/Yr)
Yale Uhiversity	New Haven, CT	Radiology	1968	1969
			1971	1973

16. List any other postgraduate medical education not accounted for in questions 14 and 15 above.

Institution	Mailing Address	Type of Service or Specialty	Dates of Attendance	
			From (Mo/Yr)	To (Mo/Yr)
Yale University School of Medicine	New Haven, CT	Radiology	7/1/68	6/30/69

17. Area of Specialty: Radiology
18. Are you Board Certified by a Board recognized by the American Board of Medical Specialties? ☒ Yes ☐ No If YES, complete the following:

Specialty Board	Certification #	Dates of:	
		Certification	Recertification
American Board of Radiology		6/23/74	

19. Location of medical practice since graduation (Include Military Service). Account for all periods of time.

City/State	From (Mo/Yr)	To (Mo/Yr)
(See attached list)		

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MEDICAL EXAMINERS

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JUN 28 1991
NEVADA STATE BOARD OF
MEDICAL EXAMINERS

20. List below the requested information for <u>all</u> hospitals of which you are, or have ever been a Staff Member at any level. If none, please indicate. Do not list internship or residency affiliation.

Hospital	Complete Mailing Address	Date of Appointment	
		From (Mo/Yr)	To (Mo/Yr)
San Pedro Pen. Hospital	1300 W. 7th Str., San Pedro, CA	10/26/88	Present
Beverly Hospital	309 W. Beverly Blvd., Montebello,CA	4/90	Present
Torrance Mem. Med. Ctr.	3330 Lomita Blvd., Torrance,CA	10/01/86	Present

21. Have you ever been licensed to practice medicine in any state or country? ☒ Yes ☐ No If YES, complete the following information:

State or Country	License #	Date of Issuance	Dates of Practice in Agency's Jurisdiction	
			From (Mo/Yr)	To (Mo/Yr)
California	G46280	10/05/81		Present
Connecticut	G046280	?		Never renewed
Florida	?	?	Never practiced	
Virginia	?	?		Never renewed

22. Have any disciplinary or administrative actions ever been taken against any healing arts license which you now hold or have ever held? Include any disciplinary and administrative actions by the U.S. Military, U.S. Public Health Service or other U.S. federal government entity. ☐ Yes ☒ No

23. Have you ever been denied a license, permission to practice medicine or any other healing arts, or permission to take an examination to practice medicine or any other healing art in any state, country or U.S. territory? ☐ Yes ☒ No

24. Have you ever had a medical license revoked, suspended, or limited in any state, country or U.S. territory? ☐ Yes ☒ No

25. Have you ever voluntarily surrendered a license to practice in the healing arts in any state, country or U.S. territory? ☐ Yes ☒ No

26. Have you ever failed a state licensure examination, any part of FLEX, any part of National Boards, or any part of ECFMG, FMGEMS or SPEX, even if subsequently passed? ☐ Yes ☒ No

27. Have you ever had staff privileges in a hospital denied, suspended, limited, revoked or not renewed, or have you ever resigned from a medical staff in lieu of disciplinary or administrative action? (PLEASE NOTE: THIS REQUIREMENT DOES NOT INCLUDE SUSPENSIONS OR RESTRICTIONS FOR FAILURE TO COMPLETE HOSPITAL MEDICAL RECORDS) ☐ Yes ☒ No

28. Have you ever been investigated for, charged with, or convicted of unprofessional conduct, professional incompetence, gross or repeated malpractice, or any other violation of a statute, rule or regulation governing the practice of medicine by any medical licensing board or other agency, hospital or medical society? ☐ Yes ☒ No

29. Have you ever been denied membership or expelled from a medical society or other professional medical organization? ☐ Yes ☒ No

30. Have you ever received psychiatric or psychologic treatment? ☐ Yes ☒ No

31. Have you ever undergone treatment for a mental illness, drug addiction, or acute or chronic substance, drug or alcohol abuse? ☐ Yes ☒ No

32. Do you regularly take any prescription drugs for therapeutic purposes? ☐ Yes ☒ No

33. Have you ever surrendered your state or federal controlled substance registration or had it restricted in any way? ☐ Yes ☒ No

34. Are you now or were you in the past, addicted to controlled substances, including, but not limited to narcotics or alcohol? ☐ Yes ☒ No

35. Have you ever been investigated for, charged or convicted of, or pled nolo contendere to a violation of any federal, state or local law relating to the manufacture, distribution, or dispensing of controlled substances, or to drug addiction? ☐ Yes ☒ No

36. Have you ever been arrested, investigated for, charged or convicted of, or pled nolo contendere to any offense, misdemeanor or felony in any state, the United States, or a foreign country? (Except violations of traffic laws resulting in fines of $75 or less.) ☐ Yes ☒ No

NOTE: You are required to list any conviction that has been set aside and dismissed under any other provision of law.

If you answered YES to any of questions 22 through 36 please explain the circumstances and disposition on a separate sheet(s) and attach to this application.

37. If granted a license, do you intend to practice in Nevada? ☒ Yes ☐ No

If YES: Location Not known Date

38. Personal Information

Age Height " Weight Color of Eyes

Color of Hair Social Security Number

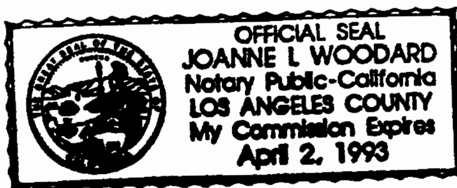
39. I, Stephen L. G. Rothman, M.D., being duly sworn, depose and say: That the answers to the foregoing questions and statements made in the above application are true and correct; that I am the person named in the credentials to be submitted; and that the same were procured in the regular course of instruction and examination without fraud or misrepresentation. It is understood by me, that if any part of this application is found to be false or fraudulent, that I forfeit the right to a medical license in the State of Nevada.

Signature of Applicant

Subscribed and sworn to before me this 24TH

day of JUNE, 1991.

(Notary Seal)


OFFICIAL SEAL
JOANNE L WOODARD
Notary Public-California
LOS ANGELES COUNTY
My Commission Expires
April 2, 1993

Notary Public for State of CALIFORNIA

My Commission Expires 4-2-93

Residing at TORRANCE, CA

Joanne L. Woodard

Stephen L. G. Rothman, M.D.
Neil I. Chafetz, M.D.

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JUN 28 1991
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MEDICAL EXAMINERS

Exact whereabouts and nature of practice from date of graduation from medical school to the present.

1. Associate Radiologist - Yale-New Haven Hospital, New Haven, CT from October 1973 to October 1974.

2. Neuroradiologist - West Haven Veterans Administration Hospital from October 1973 to January 1976.

3. Assistant Professor of Diagnostic Radiology - Yale-New Haven Hospital from October 1973 to June 1976.

4. Attending Radiologist - Yale-New Haven Hospital from November 1974 to October 1981.

5. Guest Professor - Neuroradiology - Hadassah Hebrew University Medical School from June 1985 to August 1975.

6. Administrative Director, Computerized Tomography - Yale-New Haven Hospital, February 1976 to October 1981.

7. Associate Professor of Diagnostic Radiology - Yale University School of Medicine from July 1976 to June 1981.

8. Visiting Professor of Neuroradiology - Hadassah Hebrew University Medical School from June 1978 to June 1979.

9. Consulting Neuroradiologist - Shaare Zedek Hospital from September 1978 to June 1979.

10. Professor of Diagnostic Radiology - Yale University School of Medicine from July 1, 1981 to October 15, 1981.

11. Medical Director - Multi-Planar Diagnostic Imaging, Inc., Torrance, CA from November 1981 to March 1989.

12. Visiting Consulting Radiologist (MRI) - Torrance Memorial Hospital, Torrance, CA from 9/24/86 to Present.

13. Consulting Specialist, Radiology, Spinal Cord Injury Dept. - Rancho Los Amigos Hospital, Downey, CA from 9/11/85 to Present.

14. Private practice - Rothman-Chafetz Medical Group, Inc., Long Beach, CA from March 1989 to Present.

Rothman-Chafetz Medical Group, Inc.
3400 Lomita Blvd., Suite 104, Torrance, CA 90505 • (213) 326-8744 • (800) 888-6853 • Fax (213) 715-8550

Stephen L. G. Rothman, M.D.
Neil I. Chafetz, M.D.

August 19, 1991

Betty L. Tonner
License Specialist
Nevada State Board of Medical Examiners
P.O. Box 7238
Reno, NV 89510

RE: NEVADA LICENSURE - STEPHEN L. G. ROTHMAN, M.D.

Dear Ms. Tonner:

This is in response to your letter of August 15, 1991 regarding my hospital affiliations with the following.

1) Rancho Los Amigos -

2) Rancho Encino Hospital - This letter is to advise you that Rancho Encino Hospital closed down in October of 1989 and is no longer in existence.

Other outstanding information:

3) Explanation of whereabouts from 7/69 through 10/71 - I served as a captain and then a major in the U.S. from 1969 through of 1971.

I am very anxious to have my application completed in order to be placed on the September schedule. If there is anything at all that I can do to expedite matters, please contact me and I will follow-up immediately.

Sincerely,

Stephen L. G. Rothman, M.D.

SLGR:ts

Enclosure

Rothman-Chafetz Medical Group, Inc.
3400 Lomita Blvd., Suite 104, Torrance, CA 90505 • (213) 326-8744 • (800) 888-6853 • Fax (213) 715-8550

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JUN 28 1991
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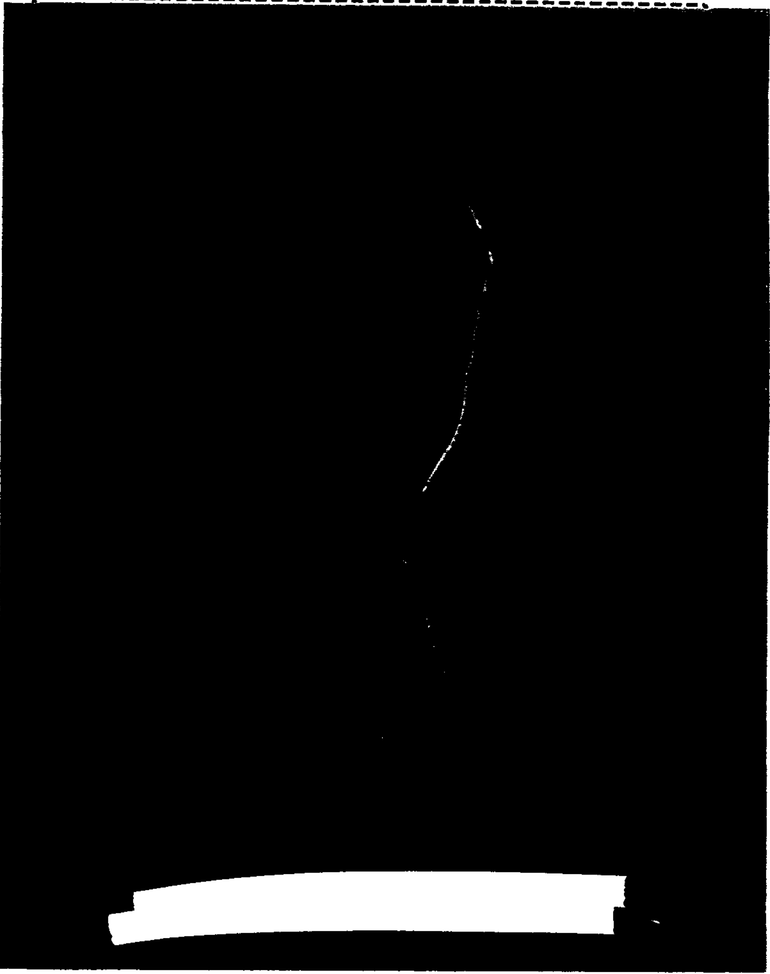
MEDICAL EXAMINERS



I hereby certify that the attached photograph is a true likeness of myself taken within the last 60 days.

Signature of Applicant

June 27 1991
Date

NOTE: All items in this application are mandatory; none are voluntary. Failure to provide any of the requested information will result in the application not being processed or being rejected as incomplete. The information provided will be used for identification and to determine qualification for licensure per Nevada Revised Statute 630 which authorizes the collection of this information.

INSTRUCTIONS

The Application, and Form A, are to be completed by the applicant, notarized as indicated, and returned to the Nevada State Board of Medical Examiners.

Forms 1 thru 6, are to be completed by the agencies or individuals indicated. It is the responsibility of the applicant to see that these are promptly returned. The completed application must be received 45 days before any examination will be administered. The forms should be separated and mailed individually, then must be returned directly to the Nevada State Board of Medical Examiners by the agencies or individuals responsible for their completion. If additional copies of any forms are needed, please photocopy.

If additional space is required for answers, separate sheets may be attached to application.

No application will be processed prior to receipt of all required fees. See fee schedule on enclosed sheet.

Application fees are non-refundable.

Please submit the application and Form A along with all required fees to:

Nevada State Board of Medical Examiners
P. O. Box 7238
Reno, NV 89510
(702) 329-2559

APPLICANT
Do Not Write In This Box
For Use At Time Of Interview

I verify that all statements made on my application for licensure in the State of Nevada received on 7-5-91, are still true and valid on 9-24-91, the date of my oral examination.

Signed: [signature]

Witness: [signature] (Board Member)

RECEIVED
JUN 28 1991
NEVADA STATE BOARD OF MEDICAL EXAMINERS

NOTICE

FAILURE TO RETURN THIS FORM CAN RESULT IN THE DELAY OF YOUR APPLICATION FOR LICENSURE

1. Have you taken all parts of the examination given by the National Board of Medical Examiners? Yes X No ___

   If answer is yes, indicate date taken. Part 1 ______

   Part 2 ______

   Part 3 ______

2. Have you taken the Special Purpose Examination (SPEX)? Yes X No ___

   If answer is yes, indicate date taken. 12/90

3. Have you taken Component II of the Federation Licensing Examination (FLEX)? Yes ___ No X

   If answer is yes, indicate date taken. ______

4. Have you taken the written portion of the examination for certification or recertification by a specialty board of the American Board of Medical Specialties? Yes ___ No ___

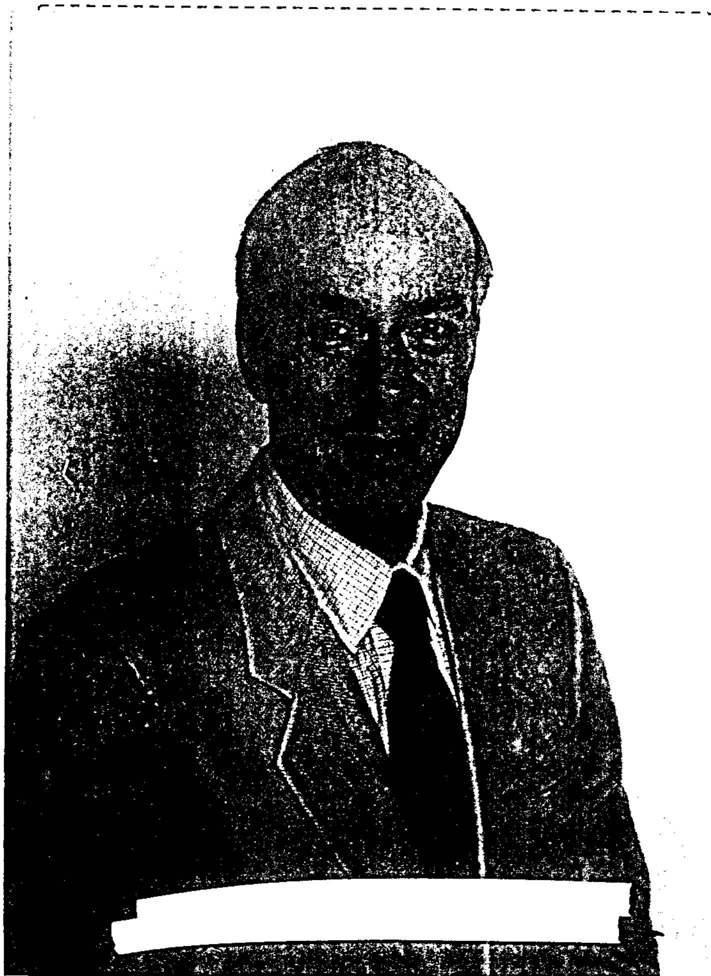
   If answer is yes, indicate date taken. ______

IF YOU HAVE NOT TAKEN ANY OF THESE EXAMINATIONS WITHIN EIGHT YEARS OF THE DATE YOUR APPLICATION IS RECEIVED BY THE BOARD, YOU WILL NEED TO SIT FOR THE SPECIAL PURPOSE EXAMINATION IN ORDER TO BE ELIGIBLE FOR MEDICAL LICENSURE IN THE STATE OF NEVADA.

______________________ Signature of Applicant

6/26/91 Date

RECEIVED
[illegible] 2 8 1991



I hereby certify that the attached photograph is a true likeness of myself taken within the last [illegible] days.

[signature]

June 24 1991

NOTE: All items in this application are mandatory; none are voluntary. Failure to provide any of the requested information will result in the application not being processed or being rejected as incomplete. The information provided will be used for identification and to determine qualification for licensure per Nevada Revised Statute 63[illegible] which authorizes the collection of this information.